

California Department of Health Care Services

Improved Monitoring of Medi-Cal Managed
Care Health Plans Is Necessary to Better Ensure
Access to Care

Report 2014-134

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June 16, 2015

2014-134

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 requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the California Department of Health Care Services' (Health Care Services) oversight of California Medical Assistance Program (Medi-Cal) managed care health plans (health plans).

This report concludes that Health Care Services did not verify that the provider network data it received from health plans were accurate. Therefore, it cannot ensure that the health plans it contracts with had adequate networks of providers to serve Medi-Cal beneficiaries. Health Care Services' contracts with health plans to provide medical services to Medi-Cal beneficiaries generally require the plans, among other things, to maintain a network of primary care providers that are located within either 30 minutes or 10 miles from a member's residence. To determine whether the health plan has an adequate provider network to meet these standards, Health Care Services receives provider network data from each of the health plans. However, for the health plans we reviewed, Health Care Services did not verify the accuracy of these data before certifying the health plans' network adequacy during the Healthy Families Program transition to Medi-Cal and did not verify data for another health plan at the time the health plan entered the Medi-Cal program. Similarly, it does not verify the accuracy of the data it receives from health plans and that it provides to the California Department of Managed Health Care (Managed Health Care), with which it has an agreement to conduct quarterly network adequacy reviews. Furthermore, it has not ensured that Managed Health Care performed all quarterly reviews of health plans' provider networks required pursuant to the agreement.

In addition, flaws in Health Care Services' process for reviewing provider directories have resulted in it approving provider directories with inaccurate information. Specifically, our review of provider directories for three health plans—Anthem Blue Cross, Health Net and Partnership HealthPlan—found many errors in directories, including incorrect telephone numbers and addresses, or information about whether they were accepting new patients. However, Health Care Services' review of these same directories had not identified these inaccuracies before it approved the directories for publication. Furthermore, we noted that thousands of calls from Medi-Cal beneficiaries seeking assistance through Health Care Services' Medi-Cal Managed Care Office of the Ombudsman have gone unanswered. Specifically, each month between February 2014 and January 2015 an average of 12,500 calls went unanswered. Finally, Health Care Services has not performed all statutorily required annual medical audits of Medi-Cal managed care health plans to determine whether the health plans meet their beneficiaries' needs.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

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Summary

Results in Brief

The California Department of Health Care Services (Health Care Services) is responsible for administering the California Medical Assistance Program (Medi-Cal), which is California's implementation of the federal Medicaid program. Medi-Cal provides health care services to aged, disabled, and low-income individuals through two different delivery systems: fee-for-service, which allows Medi-Cal beneficiaries to receive medical services from any health care provider who participates in Medi-Cal, and managed care, which requires each enrolled Medi-Cal beneficiary to receive medical services through a single provider of the beneficiary's choice within the appropriate Medi-Cal managed care health plan's (health plans) network of primary care physicians (provider network). According to Health Care Services' website, as of March 2015, more than 12.2 million Californians were enrolled in Medi-Cal, and 76 percent of these enrollees were in Medi-Cal managed care. As of that same date, Health Care Services had contracts with 22 health plans to provide managed health care services to Medi-Cal beneficiaries, whose counties of residence determined their health plan choices.¹

Health Care Services should improve its processes for verifying the health plan data that it uses to determine the adequacy of each health plan's provider network. Federal regulations require, among other things, that the State certify a health plan's participation both upon entry into Medi-Cal managed care and when it enrolls new populations in the Medi-Cal managed care program, such as when the State moved the beneficiaries of the Healthy Families Program into Medi-Cal.² Before implementing the transition, the federal Centers for Medicare and Medicaid Services required Health Care Services, among other things, to identify the beneficiaries it anticipated would be able to keep their current primary care providers after transitioning to Medi-Cal. Health Care Services obtained data from health plans, along with narrative responses, to certify that the plans met various network adequacy standards. However, Health Care Services did not verify that the provider network data it received from the health plans were accurate. Similarly, for one health plan that we reviewed, Health Care Services certified its participation in the Medi-Cal managed care program when the State expanded managed care to

¹ Health Care Services has also contracted with two additional health plans to provide specialized services, such as AIDS care, to fewer than 1,000 Medi-Cal patients. Our audit did not include these two plans and instead focused on nonspecialized service health plans.

² The Healthy Families Program provided health, dental, and vision coverage to children without insurance who did not qualify for no-cost Medi-Cal. The transition into Medi-Cal began in 2013.

Audit Highlights . . .

Our audit of the California Department of Health Care Services' (Health Care Services) oversight of the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans) revealed the following:

- » *Health Care Services did not verify health plan data; therefore, it cannot ensure that the health plans had adequate provider networks to serve Medi-Cal beneficiaries.*
- » *It cannot be certain the quarterly adequacy assessments of provider networks that the California Department of Managed Health Care (Managed Health Care) performs on its behalf are based on accurate data.*
- » *Provider directories for three health plans we reviewed—Anthem Blue Cross, Health Net, and Partnership HealthPlan—contained inaccurate information.*
- » *Health Care Services needs to improve its processes for reviewing primary care provider directories.*
- » *Thousands of calls from Medi-Cal beneficiaries to the Medi-Cal Managed Care Office of the Ombudsman (ombudsman office), which was established to investigate and resolve complaints, have gone unanswered.*
- » *Health Care Services has not consistently monitored health plans to ensure they meet Medi-Cal beneficiaries' medical needs.*
 - *It has not performed statutorily required annual medical audits of all health plans.*
 - *It has not always ensured that Managed Health Care has performed the required quarterly adequacy assessments.*

28 rural counties, but Health Care Services had not first reviewed the data that the health plan had used to demonstrate that it met the time-and-distance standard that Health Care Services requires. Health Care Services' contracts with health plans require the plans to maintain a network of primary care providers with at least one provider located within either 30 minutes or 10 miles of a beneficiary's residence unless the health plan has an alternative time-and-distance standard approved by Health Care Services.³ Without verifying the data it received from health plans, Health Care Services cannot ensure that the health plans had adequate provider networks to serve Medi-Cal beneficiaries.

Health Care Services also cannot be certain the quarterly adequacy assessments of provider networks that the California Department of Managed Health Care (Managed Health Care) performs on its behalf are based on accurate data. State law requires Health Care Services to contract with Managed Health Care to assess the adequacy of the provider networks of Medi-Cal health plans. Health Care Services receives data related to a health plan's provider network from the health plan and sends it to Managed Health Care, which uses the data to perform quarterly assessments of network adequacy. However, Health Care Services performs no substantive reviews of these data before it forwards the data to Managed Health Care. The chief of Health Care Services' Program Monitoring and Compliance Branch acknowledged that the lack of reviews has been an area identified for improvement and that Health Care Services plans to implement new processes by late 2015 to verify the accuracy and completeness of these data.

We reviewed the provider directories for three health plans in selected counties—Anthem Blue Cross in Fresno County, Health Net in Los Angeles County, and Partnership HealthPlan of California (Partnership HealthPlan) in Solano County—and found inaccuracies ranging from incorrect telephone numbers for providers to listings of providers who were no longer participating in the health plan. Using the results of our testing, we estimated that the three health plans' provider directories contain inaccurate information related to at least one of the six areas we reviewed for 3 percent to 23 percent of providers. We found that those health plans that regularly reach out to providers to update their information, such as Partnership HealthPlan, which visits each of its providers eight to 10 times per year, had fewer errors in their provider directories than did Anthem Blue Cross, which only recently began actively reaching out to its providers to update the information in its provider directories. In contrast

³ Our audit focused on primary care providers. Thus, throughout this report, the word *providers* refers to primary care providers.

to Partnership HealthPlan's provider directory, the directory for Anthem Blue Cross contained one or more inaccuracies in the provider information for 18 providers, or 23.4 percent of the 77 provider listings we reviewed. Anthem Blue Cross operates in twice as many counties as Partnership HealthPlan and has close to 2,400 providers, compared to Partnership HealthPlan's almost 800 providers.

Although the health plans we reviewed could improve their processes for reviewing provider directories, Health Care Services must also improve its own process for reviewing these provider directories. Specifically, Health Care Services did not identify any inaccuracies in the three provider directories we examined. Health Care Services requires health plans to submit updated versions of their printed provider directories every six months for its review and approval. However, Health Care Services' directory review tool, which guides its evaluation of the accuracy of the directories, is inadequate. For example, the review tool does not guide staff on how to select a sample size or how to choose the providers to contact. As a result, the methods that Health Care Services' staff has used to determine the number of providers to review have been inconsistent. Additionally, staff has used inconsistent methods to determine which providers to contact so that staff can verify their listings in the provider directory. The acting chief of Health Care Services' Managed Care Operations Division (acting chief) also stated that staff maintain documentation of inaccuracies they find during their reviews of the directories. Because staff did not find any errors, Health Care Services did not have any documentation to demonstrate that staff reviewed the three health plans' directories, as it claimed. These flaws in its review process have resulted in Health Care Services' approving provider directories with inaccurate information, which could cause Medi-Cal beneficiaries to experience difficulties in obtaining timely access to care.

State regulation allows Health Care Services to create a Medi-Cal Managed Care Office of the Ombudsman (ombudsman office) to investigate and resolve complaints by or on behalf of Medi-Cal beneficiaries about health plans. However, according to the chief of the ombudsman office, the office's telephone system cannot handle the volume of calls it receives from beneficiaries or their representatives requesting assistance, and the ombudsman office does not have adequate staff to answer all of the calls that the telephone system does accept. Ombudsman office data show that the telephone system rejected from about 7,000 to more than 45,000 calls per month between February 2014 and January 2015. Additionally, the chief of the ombudsman office stated that staffing limitations have allowed it to answer an average of just 30 percent to 50 percent of the calls that the telephone system has accepted.

Each month between February 2014 and January 2015, an average of 12,500 additional calls went unanswered. Further, the chief of the Managed Care Internal Operations Branch told us that the ombudsman office lacks an adequate database system to maintain the information related to all calls. He stated that because of hardware limitations, the database crashes frequently, resulting in loss of data. The chief stated that Health Care Services is in the process of upgrading the database to ensure data integrity, and the acting chief stated that Health Care Services upgraded its server software in March 2015 as an interim measure, and the department plans to have a new system in place during fiscal year 2015–16.

Further, Health Care Services has not consistently monitored health plans to ensure that they meet Medi-Cal beneficiaries' medical needs. State law requires Health Care Services to perform annual medical audits of all Medi-Cal health plans. However, the chief of Health Care Services' Medical Review Branch (medical review chief) stated that Health Care Services did not perform any annual medical audits before 2012. He stated that he was advised of the requirement when he assumed the position as chief in May 2011. In fiscal year 2013–14 Health Care Services performed audits of just 10 of the 22 Medi-Cal health plans. The medical review chief noted that staff are fully trained, and he is developing the schedule of audits for the next fiscal year. The goal is to comply fully with the statutory requirement in fiscal year 2015–16.

Health Care Services also has not always ensured that Managed Health Care, with which it entered into an agreement to perform quarterly assessments of provider networks for existing health plans, has performed the required assessments. Specifically, since the first quarter of 2014, Managed Health Care has not performed such assessments for health plans that have served the 28 counties that were part of the expansion of Medi-Cal managed care to rural counties. These counties had Medi-Cal enrollees of nearly 351,000 in March 2014 and had more than 515,000 enrollees in March 2015. In June 2013 the Legislature approved four limited-term positions for July 2013 through December 2014, which Managed Health Care planned to use to perform quarterly reviews. Managed Health Care did not fill these positions because the agreement to perform the quarterly reviews was not approved until June 2014, leaving little time before the expiration of the limited-term positions. Instead, Managed Health Care performed the reviews for the first quarter of 2014 with its existing staff, but it determined that it could not sustain that amount of additional work. Because Health Care Services has not ensured that Managed Health Care performed these evaluations, the State cannot be certain that the health plans are maintaining adequate provider networks to serve Medi-Cal

beneficiaries in the 28 counties. Managed Health Care told us that in May 2015 it received an increase in staffing, and it plans to resume the quarterly reviews.

Finally, Managed Health Care has an opportunity to fulfill more efficiently some of its responsibilities that overlap with the work performed by Health Care Services. Specifically, both departments are statutorily responsible for performing periodic reviews of many health plans to ensure adequate access to care for enrollees. State laws that mandate these reviews require the two departments to follow standards established under the Knox-Keene Health Care Service Plan Act of 1975. Both departments assess eight areas as part of their respective reviews, and seven of these eight areas are the same or similar, resulting in some overlapping activities. Although these state laws allow both departments to rely on each other's work to meet their responsibilities, neither department is currently relying on the work performed by the other.

Because Health Care Services must review the 22 Medi-Cal health plans more frequently than does Managed Health Care, we believe that Managed Health Care should rely on Health Care Services' reviews of the overlapping areas for 17 of the 22 Medi-Cal health plans that it licenses. The deputy director of Managed Health Care's Help Center stated that the two departments have been coordinating since 2013 to minimize duplication of work. However, this coordination is limited to sharing audit tools, coordinating logistics, and sharing audit findings and corrective actions. Further, the deputy director stated that Managed Health Care is analyzing methods to use work performed in Health Care Services' audits to meet the legal requirements for its reviews of Medi-Cal health plans going forward.

Recommendations

To ensure that Health Care Services analyzes accurately the adequacy of provider networks when initially certifying a health plan and when new beneficiary populations are added, it should establish by September 2015 a process to verify the accuracy of the provider network data the health plan uses to demonstrate that it meets network adequacy standards.

To make certain that Managed Health Care analyzes accurately the adequacy of provider networks through its ongoing quarterly assessments of provider networks, Health Care Services should establish by September 2015 a process to verify the provider network data that it receives from health plans and forwards to Managed Health Care for its review of network adequacy.

To improve the accuracy of provider directories, Health Care Services should review each health plan's process for updating and verifying the accuracy of its directory, identify best practices, and require health plans to follow those practices.

To ensure that its review of provider directories effectively identifies inaccurate information before it approves the directories for publication, Health Care Services should establish by September 2015 more detailed policies and procedures for verifying the accuracy of provider directories. Specifically, it should develop procedures for its staff to select a sample size based on the number of providers in the directory under review, ensure that the sample of providers is randomly selected, and retain all documents associated with the review for at least three years.

To ensure that it can adequately handle the volume of telephone calls from Medi-Cal beneficiaries, Health Care Services should implement an effective plan to upgrade or replace the ombudsman office's telephone system and database.

To make certain that it complies with state law requiring it to conduct annual medical audits of Medi-Cal health plans, Health Care Services should finalize and adhere to the new schedule it develops for auditing all health plans.

To ensure that it complies with state law, Health Care Services should increase its oversight of its agreements with Managed Health Care to ensure that it completes the assessments required under the agreements. Further, Managed Health Care should continue its plan to resume the quarterly reviews of provider networks in 2015.

To increase the efficiency of statutorily required reviews by eliminating duplicative work, Managed Health Care should determine by September 2015 the extent to which it can rely on Health Care Services' work to eliminate the overlap in their reviews of health plans.

Agency Comments

Managed Health Care agreed with our recommendations and indicated that it will take actions to implement them. Health Care Services generally agreed with our recommendations and outlined actions it will take to implement them. However, it disagreed with our recommendation that it increase oversight of Managed Health Care to ensure that it completes the quarterly assessments.

Introduction

Background

The federal Medicaid program provides matching funds to states to pay for the medical treatment of low-income individuals. The State participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal, which provides health care services to aged, disabled, and low-income beneficiaries. The California Department of Health Care Services (Health Care Services) is the single state agency responsible for administering Medi-Cal.

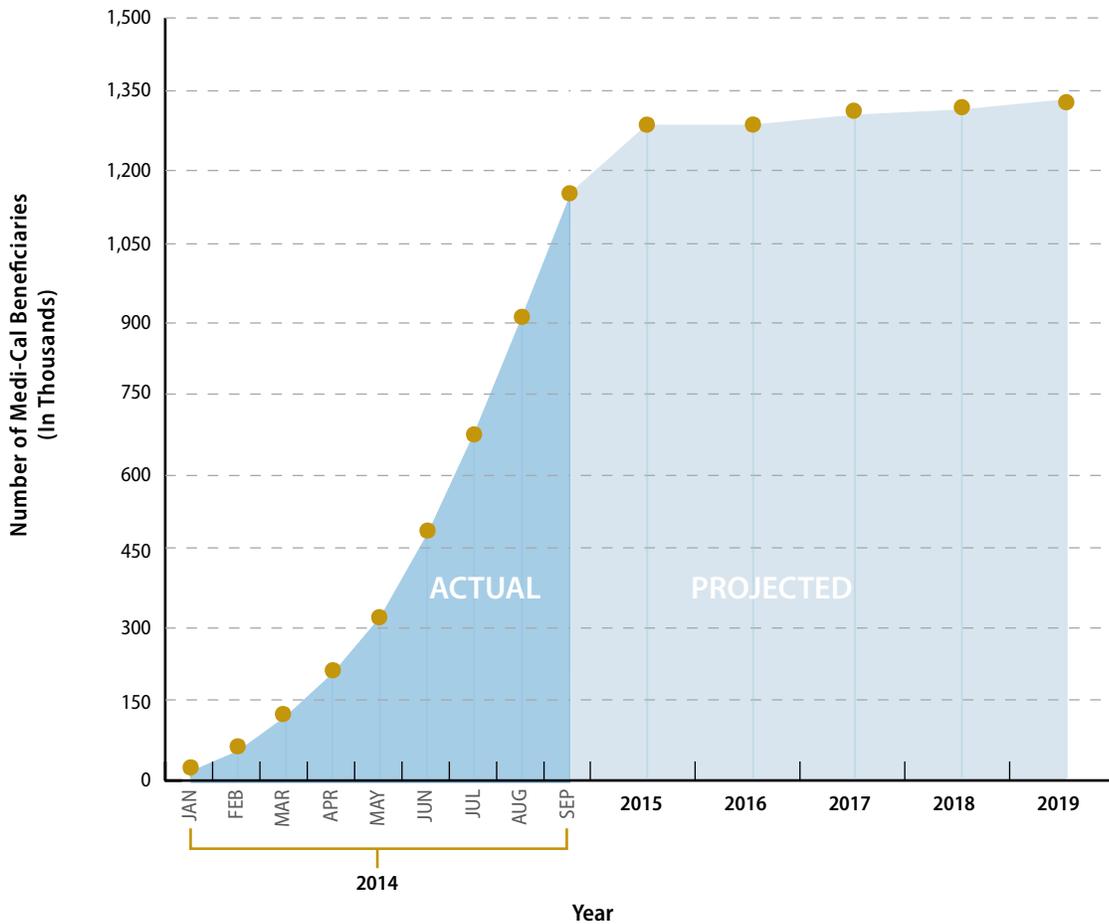
Medical providers participating in Medi-Cal receive payments under this program through one of two delivery systems: fee-for-service and managed care. Under the fee-for-service system, providers render services to Medi-Cal beneficiaries and then submit claims for payment. Under the managed care system—which is organized to manage the cost, utilization, and quality of care—medical care is provided to beneficiaries through Medi-Cal managed care health plans (health plans). Specifically, Health Care Services pays health plans a fixed amount per month for each of their enrolled Medi-Cal beneficiaries regardless of the quantity or types of medical services that the health plans deliver. The health plans, in turn, contract with medical providers. Plans are required to ensure that each enrolled beneficiary is assigned to a primary care physician who provides initial and primary care and who may refer the enrollee to a specialist based on medical needs.

Although the State contracted with managed care plans as early as 1972, the federal Centers for Medicare and Medicaid Services (CMS) did not approve the first of the currently operating managed care programs—the County Organized Health Systems (COHS)—until 1983. In August 2005 CMS provided California with authority for a demonstration project that, among its other provisions, expanded health care coverage to the uninsured in certain California counties. This demonstration project was renewed in November 2010 and renamed the California Bridge to Reform, which includes most of the State's existing Medi-Cal managed care programs.

The number of Medi-Cal beneficiaries increased considerably in 2014. Specifically, Health Care Services estimates that the changes the State made to Medi-Cal eligibility requirements in response to the Patient Protection and Affordable Care Act (Affordable Care Act) resulted in more than 1.1 million additional Californians enrolling in Medi-Cal through September 2014. In May 2014 the California Simulation of Insurance Markets—a joint project of the University of California, Berkeley, Center for Labor Research and Education and the University of California, Los Angeles, Center for

Health Policy Research—estimated that by 2019 between 1.2 million and 1.3 million individuals will have signed up for Medi-Cal because of the expansion enabled by the Affordable Care Act. Therefore, as Figure 1 shows, it appears that most of the individuals projected to enroll in Medi-Cal because of the program’s expansion have already done so.

Figure 1
Actual and Projected Additional Beneficiaries Enrolled in the California Medical Assistance Program Because of the Patient Protection and Affordable Care Act From Implementation in 2014 Through 2019



Sources: California Department of Health Care Services and the California Simulation of Insurance Markets, a joint project of the University of California, Berkeley, Center for Labor Research and Education and the University of California, Los Angeles, Center for Health Policy Research.

According to Health Care Services’ website, as of March 2015, more than 12.2 million Californians were enrolled in Medi-Cal. About 9.2 million enrollees, or 76 percent of all Medi-Cal enrollees, were in Medi-Cal health plans. Health Care Services stated that the county in which a new enrollee resides determines whether the individual must enroll in managed care or whether he or she may choose to enroll in either a managed care or a fee-for-service health plan.

When an individual applies for Medi-Cal benefits, the county assigns an aid code that dictates the types of benefits to which the individual is entitled. Health Care Services further stated that a beneficiary required to enroll in Medi-Cal managed care may be granted an exemption to remain temporarily in fee-for-service Medi-Cal if warranted by the patient's treatment plan, current medical status, or both. New beneficiaries in one county—San Benito County—may choose to enroll in either a managed care plan or fee-for-service Medi-Cal. As we discuss later, only those counties that are part of the COHS model can offer a single plan to Medi-Cal enrollees. The Social Security Act requires that beneficiaries have a choice of plans; CMS waived this requirement for the COHS model counties. Because San Benito County is not part of the COHS model and has only one health plan, the county offers fee-for-service to fulfill the federal requirement for choice.

Health Plan Options Available to Medi-Cal Beneficiaries

The health plan options available to a Medi-Cal beneficiary depend on the county in which the beneficiary resides. Counties ready for Medi-Cal managed care worked with Health Care Services to determine the specific model of Medi-Cal managed care that the county would follow. Each county participates in one of the six Medi-Cal managed care models shown in the text box. The Medi-Cal managed care model dictates the number and types of health plans offered to Medi-Cal beneficiaries in a county.

For example, a county participating in the COHS model offers only one health plan, which is created by that county's board of supervisors. Some COHS counties may choose to create their own locally initiated health plan; however, other counties may decide to join in a locally initiated plan. On the other hand, a county participating in the two-plan model offers Medi-Cal beneficiaries the option to choose from two plans—a locally initiated plan that is not part of the COHS model and a commercial plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Figure 2 on the following page shows the Medi-Cal managed care model in which each county participates. Health Care Services stated that although it contracts with two commercial plans for both regional and Imperial models, Imperial County is not part of the regional model because the counties in the regional model must be contiguous. One of the two health plans with which Health Care Services has contracted to serve beneficiaries in both the regional and Imperial models is the same, but the second plan in each model is different.

California Medical Assistance Program (Medi-Cal) Managed Care Models Available to Counties

County-Organized Health Systems: The California Department of Health Care Services (Health Care Services) contracts with a health plan created by the county board of supervisors.

Regional: Health Care Services contracts with two commercial plans.

Two-Plan: Health Care Services contracts with a county-organized plan and a commercial plan.

Geographic Managed Care: Health Care Services contracts with several commercial plans.

Imperial: Health Care Services contracts with two commercial plans.

San Benito: Health Care Services contracts with one commercial plan.

Source: Health Care Services' Medi-Cal Managed Care Program Fact Sheet.

Figure 2
County Models for California Medical Assistance Program Managed Care



Source: California Department of Health Care Services' website.

According to a chief in Health Care Services' Managed Care Systems and Support Branch, once a county was ready for Medi-Cal managed care, the county and Health Care Services entered into discussions to determine the best model for the county. Health Care Services then made a recommendation to CMS and the California Legislature to designate a particular model for the county. After approval from CMS and action by the Legislature, Health Care Services solicited bids, if applicable, and entered into contracts with health plans. Currently, Health Care Services contracts with seven commercial health plans, six plans created by counties participating in the COHS model, and nine locally initiated plans created by counties using the two-plan model. Many of these 22 health plans operate in more than one county.⁴ Table 1 shows the different health plans with which Health Care Services contracts to provide services to Medi-Cal beneficiaries in the State's 58 counties.

Table 1
California Medical Assistance Program (Medi-Cal) Managed Care Health Plans and the Counties They Serve as of March 2015

TYPE OF MEDI-CAL MANAGED HEALTH PLAN (HEALTH PLAN)	HEALTH PLAN	NUMBER OF COUNTIES SERVED	NUMBER OF ENROLLEES
County-Organized Health Systems	CalOptima	1	741,076
	CenCal Health	2	159,132
	Central California Alliance for Health	3	323,962
	Gold Coast Health Plan	1	186,744
	Health Plan of San Mateo	1	103,434
	Partnership HealthPlan of California	14	535,747
Local Initiative	Alameda Alliance for Health	1	234,036
	CalViva Health	3	307,613
	Contra Costa Health Services	1	154,970
	Health Plan of San Joaquin	2	294,707
	Inland Empire Health Plan	2	1,028,030
	Kern Family Health Care	1	194,767
	L.A. Care Health Plan	1	1,636,977
	San Francisco Health Plan	1	119,881
	Santa Clara Family Health Plan	1	221,522
Commercial	Anthem Blue Cross Partnership Plan	28	686,436
	California Health and Wellness	19	170,388
	Care 1 st Health Plan	1	67,275
	Community Health Group	1	238,801
	Health Net	7	1,318,838
	Kaiser Permanente	5	115,706
	Molina Healthcare	5	405,392
Total			9,245,434

Sources: The websites for the California Department of Health Care Services and Medi-Cal health plans.

⁴ Health Care Services has also contracted with two additional health plans to provide specialized services, such as AIDS care, to fewer than 1,000 Medi-Cal patients. Our audit did not include these two plans and instead focused on health plans providing nonspecialized services.

The Monitoring Responsibilities of Health Care Services and the California Department of Managed Health Care

Health Care Services and the California Department of Managed Health Care (Managed Health Care) are responsible for assessing each health plan's ability to serve enrollees. Federal regulations require Health Care Services to certify a health plan's participation in the Medi-Cal managed care program both at the initial entry and when new beneficiary populations are added to the program. Specifically, federal regulations require each health plan to demonstrate to the State that the health plan, among its other actions, maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medi-Cal enrollees. Federal regulations also require the State to determine whether a network of providers is sufficient based partly on the numbers of providers and enrollees and on the time and distance for an enrollee to drive to a provider. Specifically, state law and regulations require a health plan to have at least one primary care physician in a health plan's network (provider network) for every 2,000 Medi-Cal enrollees. Further, Health Care Services' contracts with health plans generally require health plans to have in their provider networks a primary care physician within 10 miles or 30 minutes of travel time from an enrollee's place of residence.

Moreover, in accordance with the state Knox-Keene Act, all commercial health plans and locally initiated health plans must obtain a license from Managed Health Care. In passing the Knox-Keene Act, the Legislature intended to promote the delivery of quality health and medical care for Californians who enroll in a managed care health plan. Although the COHS plans do not require a license from Managed Health Care to serve Medi-Cal beneficiaries, one plan has chosen to obtain a license for its Medi-Cal product; therefore, the plan is subject to the provisions of the Knox-Keene Act. To obtain a license from Managed Health Care, a health plan must file an application that includes enrollment projections, geographic area served, standards of accessibility, marketing, advertising, and current and projected financial viability. According to a health program specialist, Managed Health Care staff review the license application, recommend changes, and then allow the applicant to update its application. These reviews, changes, and updates continue until Managed Health Care's review concludes that the applicant has met the licensure requirements of the Knox-Keene Act and Managed Health Care's regulations.

Further, Health Care Services and Managed Health Care are responsible for monitoring the health plans after Managed Health Care has issued licenses to the health plans. In accordance with state law, Health Care Services has entered into two agreements with Managed Health Care to perform, among other activities,

quarterly assessments of the adequacy of provider networks for existing Medi-Cal health plans. In 2011 Health Care Services entered into a nearly \$2 million, two-year agreement that required Managed Health Care to perform quarterly network adequacy assessments of the health plans contracting with Health Care Services at that time. It later amended this agreement twice to extend services through June 30, 2015, increasing the cost of the agreement by \$1.9 million. In 2014, after the State expanded the Medi-Cal managed care program to rural counties, Health Care Services entered into a separate \$1.5 million, two-year agreement with Managed Health Care to perform, among other activities, quarterly assessments for plans serving an additional 28 counties. These quarterly assessments focus on reviewing a health plan's ability to continue serving the health care needs of its enrolled members, and the assessments take into account any changes in the health plan's provider network and number of Medi-Cal enrollees. For example, the agreement requires Managed Health Care to verify that the plan's provider network is adequate to ensure that the plan has at least one primary care provider for every 2,000 enrollees and that its provider network meets time-and-distance standards. Health Care Services is responsible for delivering to Managed Health Care various data related to the quarterly assessments, including data submitted by the health plans.

The Knox-Keene Act also requires Managed Health Care to perform reviews of all health plans it licenses at least once every three years. These reviews, generally referred to as *routine surveys*, must include reviews of the health plans' procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and overall performance in providing health care benefits and meeting the health needs of the enrollees. At the discretion of its director, Managed Health Care also performs nonroutine surveys to protect the interests of managed care members. Managed Health Care initiates nonroutine surveys, which typically have specific and limited scopes, based on issues or concerns brought to its attention through various means, such as complaints from consumers.

Similarly, state law requires Health Care Services to perform annual medical audits of health plans using standards and criteria established under the Knox-Keene Act. The purpose of these audits is to determine whether a health plan has the capacity, organization, and structure to fulfill its contractual obligations. As part of these audits, Health Care Services reviews essentially the same areas as those Managed Health Care reviews during its triennial routine surveys; however, unlike Managed Health Care, Health Care Services reviews the administrative and organizational capacity of the plan, and it does not review the plan's language assistance program. We discuss the similarities in these reviews further in the Audit Results.

Both Managed Health Care and Health Care Services maintain systems to address Medi-Cal beneficiaries' complaints related to health plans. State law requires Managed Health Care to maintain a toll-free telephone number for the purpose of receiving complaints regarding health plans that it licenses. Generally, before filing a complaint with Managed Health Care, the enrollee must work with the health plan to resolve the issues. If the enrollee is not satisfied with the decision by the health plan or if the problem is urgent, the enrollee may file a written complaint with Managed Health Care. State law requires Managed Health Care to notify the complainant in writing of the resolution of the complaint within 30 calendar days. Moreover, state regulations allow Health Care Services to designate a Medi-Cal Managed Care Office of the Ombudsman, which must investigate and resolve complaints received from Medi-Cal beneficiaries about health plans.

Health Plan Provider Directories

State regulations require each individual enrolled in a Medi-Cal health plan to select or be assigned a primary care physician. A primary care physician is a physician who has limited his or her practice of medicine to general health care or who is an internist, pediatrician, obstetrician-gynecologist, or family practitioner. If the enrollee does not select a primary care physician within 30 days of enrollment, the plan must assign a primary care physician to him or her. Any enrollee dissatisfied with a primary care physician may select or be assigned to another primary care physician.

To aid each enrollee in making an informed decision when selecting a primary care physician and services covered by the enrollee's health plan, Health Care Services' contracts with health plans require that each health plan provide the individual with an enrollment package, including a directory listing all primary care physicians in the health plan's provider network for the county in which the enrollee resides. Generally, the health plans also maintain searchable, online versions of their provider directories. Health Care Services' contracts with health plans require that the provider directories include the name, address, and telephone number of each service location; the hours and days when each facility is open; the services and benefits available; and identification of providers that are not accepting new patients. Health Care Services requires the health plans to submit updated printed provider directories every six months for its review and approval to ensure that the directories contain appropriate, accurate, and complete information about primary care providers and other services available to plan members. Twice a year Health Care Services selects a sample of providers from a health plan's directory and contacts them to verify whether the information about the providers included in the directory is accurate.

Scope and Methodology

The Joint Legislative Audit Committee directed the California State Auditor to perform an audit of the State’s Medi-Cal managed care program to determine whether Health Care Services and Managed Health Care have an appropriate framework of oversight, guidance, and assistance in place to ensure that Medi-Cal health plans have accurate provider directories and an adequate provider network to serve Medi-Cal beneficiaries.

Table 2
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant state and federal laws and regulations significant to the audit objectives.
2 For both the California Department Health Care Services (Health Care Services) and the California Department of Managed Health Care (Managed Health Care), determine whether these departments have an appropriate regulatory framework of oversight, guidance, and assistance in place to ensure that the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans) have accurate provider directories and an adequate network of providers to serve Medi-Cal beneficiaries. Specifically:	
a. Determine how these departments provide oversight and ensure that health plans have accurate provider directories and adequate provider networks.	<p>To determine how Health Care Services and Managed Health Care provide oversight and ensure that health plans have accurate provider directories, we did the following:</p> <ul style="list-style-type: none"> • Interviewed key management personnel at Health Care Services to understand activities and processes for ensuring accuracy of provider directories. • Obtained and reviewed documentation supporting Health Care Services’ activities. • Interviewed key management personnel at Managed Health Care and determined that Managed Health Care does not have a regular process for ensuring the accuracy of provider directories. <p>To determine how Health Care Services and Managed Health Care provide oversight and ensure that health plans have adequate provider networks, we did the following:</p> <ul style="list-style-type: none"> • Interviewed key management personnel at Health Care Services and Managed Health Care to understand the activities and processes used to ensure that health plans have adequate provider networks. • Reviewed Health Care Services’ most recent certification of three health plans when new populations were added to those plans and determined whether it followed its processes. • Reviewed one initial plan certification completed in 2013 for a health plan that now serves Medi-Cal managed care beneficiaries. • Reviewed Managed Health Care’s licensure of selected health plans and determined whether it reviewed key information about the health plans before issuing licenses. • Reviewed eight quarterly network adequacy reviews for three plans that Managed Health Care performed for quarters between July 2012 and July 2014 and determined whether it performed key procedures.

continued on next page...

AUDIT OBJECTIVE	METHOD
<p>b. Evaluate whether these departments have sufficient staff and resources and appropriate evaluation tools to monitor and ensure that health plans keep provider directories up to date and maintain adequate provider networks.</p>	<p>To determine whether these departments have sufficient staff and resources, we did the following:</p> <ul style="list-style-type: none"> • Interviewed key managers for each unit responsible for oversight of health plans to understand their staffing needs and current staffing levels. • Assessed the impact of staffing shortages on the oversight of health plans. • Reviewed the actions the departments have taken to address staffing shortages. <p>To determine whether these departments have appropriate evaluation tools to monitor and ensure that health plans keep up-to-date provider directory and adequate provider networks, we reviewed network adequacy evaluation tools and a provider directory review tool to determine if they were effective.</p>
<p>c. Identify and evaluate the sufficiency of these departments' programs, policies, and procedures for ensuring health plans have accurate provider directories.</p>	<ul style="list-style-type: none"> • Interviewed management and staff in Health Care Services' Medi-Cal Health Division and obtained relevant documents to verify programs, policies, and procedures. <p>Managed Health Care does not regularly perform procedures to ensure the accuracy of provider directories.</p>
<p>d. Determine the circumstances under which these departments would require health plans to provide verification of submitted provider network data.</p>	<p>Interviewed managers at Health Care Services and Managed Health Care and reviewed relevant documentation to determine the extent to which the two departments require verification of submitted provider network data.</p>
<p>3 Determine whether Health Care Services and Managed Health Care have policies and programs in place to ensure that health plans are adequately meeting the health care needs of Medi-Cal beneficiaries.</p>	<p>Based on the steps described for Audit Objective 2, we assessed the adequacy of Health Care Services' and Managed Health Care's policies and programs to ensure that health plans are meeting the health care needs of Medi-Cal beneficiaries.</p>
<p>4 Select three health plans from three different counties to determine how they ensure adequate access to medical providers for the populations they serve. Specifically, determine the following:</p>	<p>Selected health plans to capture different types of plans participating in the program across the State. We focused on the counties with a relatively larger beneficiary population within each selected health plan. We selected Health Net in Los Angeles County, Anthem Blue Cross in Fresno County, and Partnership HealthPlan of California in Solano County.</p> <p>For these health plans, we did the following to address the specified items:</p>
<p>a. Whether provider directories that the health plans submit to Health Care Services and Managed Health Care are accurate and comply with federal and state laws and regulations.</p>	<ul style="list-style-type: none"> • Reviewed relevant laws and regulations related to provider directories. • Obtained the most recent provider directories that had been reviewed and approved by Health Care Services. • Selected a statistically valid sample of primary care providers from each directory. • Called each selected provider's office to verify the information contained in the directory. See Appendix A for details on the process and questions associated with these calls.
<p>b. Whether provider directories the health plans provide to consumers and enrollees are consistent with Health Care Services' internal records of providers that serve Medi-Cal health beneficiaries.</p>	<ul style="list-style-type: none"> • Reviewed Health Care Services' policy letters and the contracts with health plans to determine the requirements for publishing provider directories. • Obtained the most recent provider directories approved by Health Care Services for the three selected health plans. • Compared the latest provider directories that each of the three selected health plans provided to its enrollees with those Health Care Services approved. <p>Nothing significant came to our attention.</p>

AUDIT OBJECTIVE	METHOD
<p>c. Assess, to the extent possible, whether the health plans perform ongoing oversight to ensure Medi-Cal beneficiaries have adequate access to providers.</p>	<ul style="list-style-type: none"> • Interviewed key staff to identify the process each health plan has employed to provide oversight of providers to ensure Medi-Cal beneficiaries have adequate access to providers. • Reviewed relevant documentation related to oversight activities to ascertain that the health plan followed its own process. • Obtained data from the health plans to select complaints and grievances from Medi-Cal beneficiaries related to access to providers. However, we did not validate the completeness of the universe from which we made our selection. The results of our review showed that the health plans addressed 20 complaints and grievances reviewed in a timely and appropriate manner. • In Appendix B, we describe the processes each health plan has employed to provide oversight of providers. <p>Nothing came to our attention to suggest that these processes were not adequate.</p>
<p>d. Determine, to the extent possible, how often the health plans review the accuracy of their provider lists and ensure that each provider listed participates in Medi-Cal and is accepting Medi-Cal patients.</p>	<ul style="list-style-type: none"> • Interviewed key staff to understand the process each health plan employed to ensure accuracy of the provider directory. • Reviewed relevant documentation to determine whether each health plan has followed its process.
<p>e. Evaluate, to the extent possible, the health plans' practices to assist Medi-Cal beneficiaries who have trouble locating a provider.</p>	<ul style="list-style-type: none"> • Interviewed key staff to understand each health plan's practices for assisting Medi-Cal beneficiaries. • Reviewed selected contacts and complaints each health plan received during 2013 and 2014 to determine whether the health plan appropriately assisted the beneficiary. <p>We found that the three health plans adequately addressed the beneficiaries' requests for assistance.</p>
<p>f. Evaluate, to the extent possible, the process the health plans use to recruit and retain providers.</p>	<ul style="list-style-type: none"> • Interviewed key staff to understand the process each health plan employs to recruit and retain providers. • Reviewed relevant documentation to ascertain the processes described by each health plan. <p>We present these processes in Appendix B.</p>
<p>5 Review and assess any other issues that are significant to the accuracy of provider directories and the adequacy of the networks of providers for individuals enrolled in the Medi-Cal health plan.</p>	<p>To determine whether Health Care Services and Managed Health Care addressed complaints from Medi-Cal beneficiaries in a timely and appropriate manner, we performed the following:</p> <ul style="list-style-type: none"> • Interviewed key staff responsible for overseeing consumer complaints and grievances. • Selected five complaints or grievances related to health plans during 2013 and 2014 from each department using data we obtained from Health Care Services' Microsoft Dynamics (Dynamics) System and Managed Health Care's Clarify system. However, because the Dynamics System is primarily paperless, we did not validate the completeness of the universe from which we made our selection. Further, we evaluated the completeness of Managed Health Care's Clarify system, and the results are included in Table 3. • Reviewed the documentation related to the selected complaints and grievances and determined that the resolutions to those complaints and grievances were reasonable in terms of timing and action taken.

Sources: California State Auditor's analysis of the Joint Legislative Audit Committee's audit request number 2014-134 and information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained electronic data files extracted from the information systems listed in Table 3. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support our findings, conclusions, or recommendations. Table 3 describes the analyses we conducted using data from these information systems, our methodology for testing them, and the conclusions we reached as to the reliability of the data. Although these determinations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Table 3
Methods Used to Assess Data Reliability

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
California Department of Managed Health Care (Managed Health Care) Clarify Managed Health Care's Medi-Cal grievance data for 2013 and 2014	To select five grievances for testing the timeliness and appropriateness of their resolutions.	<ul style="list-style-type: none"> This purpose did not require a data reliability assessment. Instead, we gained assurance the population was complete. We performed data-set verification and electronic testing of key data elements and found no issues. To test the completeness of the grievance data, we traced 29 haphazardly selected grievance files for 2013 and 2014 to the grievance data and found no errors. 	Complete for the purpose of this audit.
California Department of Health Care Services' (Health Care Services) Medi-Cal Managed Care Office of the Ombudsman (ombudsman office) AT&T Call Management Call management data containing the Ombudsman office's contact and case statistics for January 2013 through January 2015	To identify trends in ombudsman office contacts and cases from January 2013 through January 2015.	We did not perform accuracy and completeness testing on these data because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although these determinations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from Managed Health Care and Health Care Services.

Audit Results

The California Department of Health Care Services Did Not Verify Important Provider Network Data for the California Medical Assistance Program Managed Care Health Plans

The California Department of Health Care Services (Health Care Services) should improve its processes for verifying the data that it uses to assess whether the networks of primary care physicians (provider networks) established by the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans) are adequate. Federal regulations require, among other things, that the State certify a health plan's participation in the Medi-Cal managed care program. Before it issues this certification, Health Care Services requires the health plan to provide an analysis demonstrating that its provider network meets certain standards for the accessibility of its services to the health plan's enrollees. Health Care Services has processes to verify some information, such as confirming a sample of contracted providers and recalculating certain ratios based on some of its own data. However, Health Care Services' certification process does not include verifying the data used to demonstrate the adequacy of a health plan's provider network. Further, for each health plan already certified to participate in Medi-Cal managed care, Health Care Services also performs quarterly reviews of provider network adequacy through agreements with the California Department of Managed Health Care (Managed Health Care). As with its certification process, however, Health Care Services does not verify the accuracy of the provider network data it receives from the health plans and provides to Managed Health Care for the quarterly reviews. Without first verifying the provider network data, Health Care Services cannot be certain that the health plans maintain adequate provider networks to meet the medical needs of Medi-Cal beneficiaries enrolled in those health plans.

Health Care Services Has Certified Health Plans' Provider Networks Without Verifying the Underlying Provider Network Data

Federal regulations and Health Care Services' contracts with health plans outline standards for provider network adequacy that health plans must follow to participate in the Medi-Cal managed care program. Federal regulations require, among other things, that the State certify a health plan's participation in the program both at the health plan's entry and when new beneficiary populations are added to the program. Additionally, federal regulations mandate that each health plan provide the State with documentation demonstrating that the health plan's services are available and accessible to the expected number of beneficiaries in

the health plan's service area. Health Care Services has defined this accessibility in its contracts with health plans. The contract terms, in part, require health plans to maintain a network of primary care physicians so that at least one provider is located within either 30 minutes or 10 miles of each enrollee's residence unless Health Care Services has approved an alternative time-and-distance standard. Health Care Services most recently certified health plans when the State eliminated the Healthy Families Program and moved most of its participants into health plans within Medi-Cal.⁵

For this recent certification, Health Care Services obtained approval from the federal Centers for Medicaid and Medicare Services (CMS) to move the beneficiaries of the Healthy Families Program into Medi-Cal beginning in January 2013. In its approval of the transition, CMS required the State to demonstrate certain activities, such as the health plans' successful provision of coverage to children and their provider network adequacy. For example, CMS required that before implementing the transition, the State had to estimate the percentage of Healthy Families Program beneficiaries it anticipated would be able to keep their current primary care providers after the transition. We reviewed three health plans—Anthem Blue Cross in Fresno County, Health Net in Los Angeles County, and Partnership HealthPlan of California (Partnership HealthPlan) in Solano County—during this audit. For the three health plans we reviewed, Health Care Services stated in its certification to CMS that each of the plans had a sufficient provider network in place to provide all primary care physicians necessary to transitioning Healthy Families Program enrollees. Health Care Services also stated that these health plans could provide a high number of enrollees transitioning from the Healthy Families Program with the ability to maintain their current health care providers. However, Health Care Services did not verify some of the data that informed these certifications.

In February and April 2013, Health Care Services certified to CMS that the three health plans we reviewed would have available services; it based this certification on the number of providers in the health plans' provider networks who participated both in the Healthy Families Program and in existing Medi-Cal health plans. Health Care Services analyzed the provider network data it obtained from the three health plans we reviewed to determine which providers in their Healthy Families Program networks overlapped with providers in their Medi-Cal networks. However, Health Care Services did not verify that the provider network data it received from the health plans were accurate. Instead, it relied

Health Care Services did not verify that the provider network data it received from the health plans were accurate.

⁵ The Healthy Families Program provided health, dental, and vision coverage to uninsured children who did not qualify for no-cost Medi-Cal.

on the health plans' electronic certification that the data submitted were accurate. Nevertheless, reliance on this type of certification is not a sufficient substitute for performing some verification of accuracy. Health Care Services also supplied a report on the Healthy Families Program transition to Medi-Cal that offered detailed statistics about the ability of these three health plans to participate in this transition, such as the percentage of primary care physicians who were not accepting new patients and the percentage of Healthy Families Program beneficiaries who could keep their primary care providers. However, Health Care Services could not show documentation indicating how it calculated these values from the health plans' data. As a result, Health Care Services cannot support with accurate data that it ensured that these health plans had adequate provider networks for the transition of Healthy Families Program beneficiaries to Medi-Cal health plans.

In addition to using health plan data, Health Care Services also based its certifications on other factors, including qualitative factors. For example, Health Care Services provided CMS with the survey responses from the three health plans that identified how the plans would ensure the continued care of beneficiaries who could not maintain their primary care providers. The survey also asked health plans to provide a description of their efforts to contract with the Healthy Families Program providers who were not already in the health plans' Medi-Cal provider networks. Health Care Services also met the federal requirements for provider network adequacy related to including specific terms in its contracts with the three health plans we reviewed, such as requiring the plans to offer services to enrollees 24 hours a day, seven days a week when medically necessary. Further, CMS required the State to ensure that each plan has an accessible network with reasonable geographic proximity to beneficiaries. Health Care Services indicated in its certification that because there was no geographical expansion of coverage, only a population expansion, it performed limited review in this area—comparing the Healthy Families Program's provider network with the health plans' provider networks to ensure there would be the same coverage.

We also selected and reviewed one initial plan certification completed in 2013 for California Health and Wellness—a health plan that now serves Medi-Cal managed care beneficiaries in Imperial County. When the State expanded Medi-Cal managed care into 28 rural counties in 2013, federal regulations required the State to determine, among other things, whether the health plans that wanted to participate in Medi-Cal managed care in these counties had the numbers of providers required to furnish services to beneficiaries as well as a provider network at locations within the time-and-distance standards. State law covering health plans that are licensed under the Knox-Keene Health Care Service Plan

Health Care Services cannot support with accurate data that it ensured that health plans had adequate provider networks for the transition of Healthy Families Program beneficiaries to Medi-Cal plans.

Act of 1975 (Knox-Keene Act) requires health plans to have at least one primary care physician for every 2,000 beneficiaries. Moreover, Health Care Services' contracts with health plans require them to maintain a provider network of primary care physicians located within 30 minutes or 10 miles of members' residences unless the health plan has an alternate time-and-distance standard approved by Health Care Services.

In certifying California Health and Wellness, Health Care Services reviewed various areas related to provider network adequacy. For example, it verified that the health plan had enough primary care physicians to accommodate the expected number of plan beneficiaries. Health Care Services also used the number of beneficiaries in Imperial County to calculate the minimum number of primary care physicians needed to maintain a ratio of at least one provider for every 2,000 beneficiaries. Further, it verified plan data on the number of primary care physicians by obtaining written agreements between primary care providers and California Health and Wellness. Health Care Services reported that it reviewed 5 percent of all primary care physicians, or nine providers, claimed by the health plan. Health Care Services also reviewed the expected utilization of services for the health plan and whether providers were accepting new patients.

Health Care Services did not verify the data that California Health and Wellness used to demonstrate that it met the time-and-distance standards.

However, Health Care Services did not verify the data that California Health and Wellness used to demonstrate that it met the time-and-distance standards. Health Care Services required the health plan to submit a geographic access report to demonstrate that it met the time-and-distance standards. This report included a map showing the parts of the health plan's service area that its provider network could serve, taking into account the required time-and-distance standards. The report also included a summary of the number of enrollees in the service area who would not have access to the health plan's provider network within the required time-and-distance standards. This geographic access report's information allowed Health Care Services to determine whether the health plan needed to take any steps to mitigate the lack of accessibility, such as providing transportation services to enrollees. Because some providers practice at multiple locations, this report took into consideration the multiple locations where the health plan's providers practiced. However, Health Care Services' review tool for geographic access reports does not include a step directing staff to verify the number of provider locations that the health plan used in its geographic access report. It is important for Health Care Services to verify the providers' location information so that it can ensure that health plans provide enrollees with adequate access to providers.

The acting chief of Health Care Services' Managed Care Operations Division (acting chief) believes its existing processes for certifying initial provider networks are adequate and does not believe that health plans are misstating their provider networks in the geographic access reports. Further, Managed Care Systems and Support Branch staff cited an analysis that Health Care Services performs on zip codes that do not have appropriate coverage by primary care providers. However, Health Care Services performs this analysis only when a health plan identifies gaps in provider coverage based on the health plan's geographic access report. Managed Care Systems and Support Branch staff further cited another review that Health Care Services performed comparing the provider network it approved under Medi-Cal's fee-for-service plans and the network certification that we reviewed. Health Care Services' review found that the provider network that the plan proposed had 109 providers in common with the fee-for-service provider network. However, because the health plans included providers who might not have participated in Medi-Cal's fee-for-service plans, Health Care Services' comparison of the two provider networks would not have ensured the accuracy of the health plans' provider network data.

Health Care Services Does Not Verify the Accuracy of the Data Used for the Required Ongoing Assessments of Provider Networks

In addition to performing initial reviews of provider network adequacy, Health Care Services has established agreements with Managed Health Care, as state law requires, to perform ongoing reviews of provider network adequacy. The agreements require Managed Health Care to assess quarterly the adequacy of provider networks, and these assessments are to include a review of current geographic access for plan members using data that Health Care Services obtains from the health plans and forwards to Managed Health Care. Upon completing its assessment, Managed Health Care is required under the agreements to provide the results to Health Care Services.

However, Health Care Services does not verify the accuracy of the provider network data it receives from health plans and sends to Managed Health Care. Specifically, Health Care Services issued a policy letter in March 2014 requiring each existing health plan to submit monthly its provider file, which includes the health plan's provider network data, such as the names and addresses of providers. The policy letter also specifies the methods the health plans should use to organize and submit their monthly file of provider data, and it states that the data submission requirement will help Health Care Services ensure the accuracy of the provider data and the adequacy of health plans' provider networks. Because Health Care Services is

Health Care Services does not verify the accuracy of the provider network data it receives from health plans and sends to Managed Health Care.

Without verifying the accuracy of the provider network data received from the health plans, Health Care Services cannot be certain that the health plans have adequate provider networks that meet the access standards that aim to help health plan beneficiaries find and receive health care.

obligated by its agreement to provide these data to Managed Health Care to use in determining whether a health plan continues to have an adequate provider network, we would expect Health Care Services to review the data, at least on a sample basis, to verify their accuracy. For example, it could verify the address information of a sample of providers included in the health plan's data by contacting providers directly. However, Health Care Services does not review the data before it forwards the information to Managed Health Care even though such reviews would enable Health Care Services to have confidence in the data it receives from the health plans.

Without verifying the accuracy of the provider network data received from the health plans, Health Care Services cannot be certain that the health plans have adequate provider networks that meet the access standards that aim to help health plan beneficiaries find and receive health care. Whether initially certifying the health plan or providing data to Managed Health Care for the quarterly reviews, Health Care Services is vulnerable to inaccurate provider network analyses because it does not have processes for verifying this information. Ensuring that the health plans are not overstating their provider network data is especially important considering that our review of provider directories found that one health plan's directory listed providers who no longer participate in that plan, as we discuss later. Health Care Services' lack of a process to verify the accuracy of the data it uses to determine the adequacy of provider networks could lead to an incorrect conclusion about a health plan's ability to provide Medi-Cal beneficiaries with timely access to medical care.

The chief of Health Care Services' Program Monitoring and Compliance Branch (branch chief) stated that when Health Care Services receives the provider files from the plans, it ensures that the data fields are filled in, but it does not perform any further process or quality check on the data. He acknowledged that Health Care Services has identified this omission as an area for improvement and stated that Health Care Services has included it as a component of its project plan to revamp its monitoring of provider network adequacy. Specifically, the project plan, scheduled for implementation in the latter part of 2015, includes Health Care Services' establishing a process to verify the data in the provider files submitted by the health plans. Further, the branch chief noted that Health Care Services' project plan requires the establishment of a process to validate submissions of provider data files and that its measuring the quality of provider data files will likely act as an incentive for health plans to submit quality data. As the

text box shows, Health Care Services plans to verify the accuracy, completeness, reasonableness, and timeliness of the provider data it receives from the health plans.

Health Care Services Has Not Ensured That Medi-Cal Managed Care Health Plans Publish Accurate Provider Directories

The three health plans we reviewed included inaccurate information in their provider directories, and Health Care Services' review did not identify these inaccuracies before it approved the directories' publication. We found many errors in the directories, including errors related to providers' telephone numbers and addresses as well as to whether the providers were accepting new patients. Although all three health plans indicated that they rely on providers to notify them of changes, we found that the two health plans that actively reached out to providers in their provider network to update information generally had fewer inaccuracies than did the one health plan that only recently began reaching out actively to providers to update its information. When errors occur in the providers' directories, Medi-Cal beneficiaries could experience delays in their access to care.

Characteristics of Medi-Cal Managed Care Health Plans' Data About Providers That the California Department of Health Care Services Intends to Verify

- **Accuracy**—The California Department of Health Care Services (Health Care Services) intends to compare provider data entries to other provider data, such as plan financial records.
- **Completeness**—Health Care Services intends to compare provider data to external sources, such as providers' contracts with the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans).
- **Reasonableness**—Health Care Services intends to compare a health plan's entire data set against reasonable standards or expectations.
- **Timeliness**—Health Care Services intends to compare provider data entries to other available data, such as information on contract execution dates. For example, it intends to compare the contract execution date to the month that the health plan included the provider in its data submission.

Sources: Chief of Health Care Services' Program Monitoring and Compliance Branch within the Medi-Cal Managed Care Quality and Monitoring Division as well as its April 2015 Network Adequacy Monitoring Project outline.

The Three Provider Directories We Reviewed Contained Varying Degrees of Inaccurate Information

Our review of provider directories for three health plans found that the directories did not always contain accurate data about providers, such as telephone numbers, addresses, or information about whether they were accepting new patients. We reviewed a statistically valid sample of providers for three Medi-Cal managed care plans. Specifically, we reviewed certain information related to a sample of providers that Anthem Blue Cross included in its provider directory for Fresno County and that Health Care Services approved in December 2014. We also reviewed information for a sample of providers included in Health Net's provider directory for Los Angeles County and for Partnership HealthPlan in Solano County that Health Care Services approved in August 2014. See Appendix A beginning on page 43 for further details on the process we used for this review, including the sample selection methodology and the questions we asked each provider we contacted.

We found inaccuracies related to 18, or 23.4 percent, of the 77 providers we reviewed from Anthem Blue Cross's provider directory for Fresno County, and for others sampled from Health Net's provider directory, we found inaccuracies related to 11 providers, or 11.8 percent.

Although the directories for all three health plans contained some inaccurate information, two of the three health plans' directories contained errors related to several providers, while the third health plan, which lists fewer providers, contained only one error. Because the directories of the three health plans had varying numbers of providers, and because we used a statistically valid sample size, the number of providers we surveyed for each plan differed. Specifically, we found inaccuracies related to 18, or 23.4 percent, of the 77 providers we reviewed from Anthem Blue Cross's provider directory for Fresno County. Similarly, for the 93 providers we sampled from Health Net's provider directory, we found inaccuracies related to 11 providers, or 11.8 percent. In contrast, we found inaccuracies related to only one, or 3.1 percent, of the 32 providers we reviewed from Partnership HealthPlan's provider directory.

Although we expected that a provider directory might contain some outdated information at any given time because of the time needed to update the information, our review identified many errors that did not seem reasonable because of the length of time that the errors were outstanding. For example, a telephone number for a provider listed in Anthem Blue Cross's directory belonged to a personal residence, and the individual to whom we spoke informed us that she had been receiving calls from Anthem Blue Cross's enrollees for more than a year. In another instance, a staff member for one of Anthem Blue Cross's providers indicated that the provider's office had moved two or three years ago, but the directory still reflected the old address. Further, staff at an office that was listed in Health Net's directory told us that the provider had left the office in June 2014.

Based on the results of our testing, an estimated 3 percent to 23 percent of provider directory listings have inaccuracies in at least one of the six areas we reviewed. We consulted a statistician to verify our sample selection methodology and to help us project the errors in the provider directories. Table 4 provides a summary of the percentage of errors we found in our testing of six areas and our resulting projection of the number of provider directory listings that have incorrect information.

Each of the inaccuracy rates and projections we identify in Table 4 has a different margin of error. The margin of error is the uncertainty associated with an estimate that is based on data gathered from a sample of the population rather than from the full population. For example, we surveyed 93 of the 2,468 providers listed in Health Net's provider directory for Los Angeles County. We were unable to reach two of the 93 providers because the telephone numbers listed for them in the provider directories were incorrect. We found that for six, or 6.6 percent, of the

91 providers’ offices we were able to reach, staff indicated that the listed provider was no longer practicing at that location or that they did not know the provider. Using this error rate, we project that the addresses for 163 of the 2,468 providers in this directory were incorrect. Although 6.6 percent represents our best estimate of the error rate for the entire directory, given a margin of error of plus or minus 5 percent, we estimate that the errors in the directory could represent as few as 39, or 1.6 percent, of provider listings or as many as 286, or 11.6 percent, of provider listings.

Table 4
Percentages of Errors Uncovered in Our Review of Selected California Medical Assistance Program Managed Care Health Plans’ Provider Directories and Projected Numbers of Provider Listings With Incorrect Information

NUMBER OF PROVIDERS IN DIRECTORY	NUMBER OF PROVIDERS REVIEWED	INCORRECT PROVIDER TELEPHONE NUMBER	INCORRECT PROVIDER NAME (NOT AT ADDRESS)	INCORRECT PROVIDER ADDRESS	INCORRECT PRACTICE TYPE (PEDIATRICS, FAMILY PRACTICE)	PROVIDER NOT ACCEPTING MEDI-CAL MANAGED CARE HEALTH PLAN (HEALTH PLAN) COVERAGE	INCORRECT PROVIDER STATUS (OPEN OR CLOSED TO NEW PATIENTS)	PROVIDERS WITH INCORRECT INFORMATION IN ONE OR MORE AREAS REVIEWED
Anthem Blue Cross—Fresno County*								
383	77	5.2%	6.8%	5.9%	3%	4.5%	7.5%	23.4%
Projected number of provider directory listings with errors		20	26	23	11	17	29	90
Health Net—Los Angeles County*								
2,468	93	2.2%	6.6%	1.2%	0%	0%	3.7%	11.8%
Projected number of provider directory listings with errors		53	163	30	0	0	90	292
Partnership HealthPlan of California—Solano County*								
47	32	0%	0%	0%	0%	0%	3.1%	3.1%
Projected number of provider directory listings with errors		0	0	0	0	0	1	1

Source: California State Auditor’s analysis of testing results from its review of the accuracy of provider directories from three Medi-Cal health plans.

* The percentages represent our best estimates of the error rates in the provider directories, given a 95 percent confidence level. Each number has a unique margin of error.

During our review of the three health plans and their directories, we found that these health plans had updated their online provider directories to correct some of the inaccuracies we identified through our survey. We did not include these corrected inaccuracies in our error rates. For example, in reviewing the 77 providers listed in Anthem Blue Cross’s directory, we found inaccuracies related to six providers’ telephone numbers. However, when we consulted the health plan’s online directory, we found that the health plan had corrected the telephone number for one provider and removed another provider from its listings.

Health Plans' Varied Processes for Reviewing Provider Directories Likely Account for the Differing Levels of Directory Errors

The process that each of the three health plans employs to update its provider directory may have contributed to the variations in the number of inaccuracies we found. The acting chief confirmed that Health Care Services does not specify the method that a health plan should use when verifying its provider network information. As a result, the three plans we reviewed verify this information in different ways even though each plan stated that it relies on providers to notify the health plan about any changes in their telephone numbers or physical addresses, whether the providers are accepting new patients, and other information. We found that each of the two health plans we reviewed that had a process for regularly reaching out to providers to update their information had fewer provider directory inaccuracies than the health plan that only recently began reaching out to providers.

Specifically, Partnership HealthPlan regularly contacts its providers to maintain updated directory information. According to its associate director of regulatory affairs, Partnership HealthPlan requires its providers to notify it within 30 days of any changes that affect the provider directory. In addition, Partnership HealthPlan's procedures require its staff to visit each of its primary care providers eight to 10 times per year and to identify any changes in provider information during these visits. Using information gathered during these visits, the health plan actively updates its provider directory. The frequent interactions with its providers give Partnership HealthPlan a way to identify changes in provider information quickly, even if the provider fails to notify the health plan of the changes. In fact, as we discussed previously, of the 32 providers reviewed for Solano County, we identified only a single error in the providers we reviewed. The Partnership HealthPlan associate director told us that it uses the same process for updating information related to 793 primary care physicians in its provider network for 14 counties serving Medi-Cal beneficiaries.

Health Net's process for updating provider information does not involve as many contacts with the providers as the process used by Partnership HealthPlan.

Health Net's process for updating provider information does not involve as many contacts with the providers as the process used by Partnership HealthPlan: Health Net's provider network management director told us that Health Net reaches out to each provider twice a year to verify or update provider information. She explained that Health Net staff perform multiple follow-ups with providers, including faxing letters and contacting the provider's medical group by telephone. She stated that Health Net aims to ensure that it obtains a response rate of at least 90 percent of providers, and it excludes providers from its directories who do not respond to this verification process. According to its Medicaid compliance manager, Health Net uses the same process for

updating information related to the 3,575 primary care physicians in its provider network for all seven counties in which it serves Medi-Cal beneficiaries.

However, the Medicaid compliance manager told us that Health Net staff did not fully follow the usual process of excluding nonresponsive providers when updating its Los Angeles County provider directory for August 2014, which was the directory we reviewed. She stated that the results of the directory update vary from previous results because Health Net received a poorer provider response to the multiple outreach initiatives than had occurred in the past. She noted that during that time Health Net had significant communication and outreach to the provider community related to other plan activities, including the Patient Protection and Affordable Care Act implementation and expansion of Medi-Cal. These same activities led to an unusual increase in workload for its regional team and to deviation from the usual process. Health Net, therefore, included information about providers in its provider directory that it had not verified through its usual process. Specifically, according to its provider response spreadsheet, it did not receive a response rate of at least 90 percent from its Los Angeles County providers, and it did not exclude all nonresponsive providers from its August 2014 directory. As discussed previously, in our review of the accuracy of information in Health Net's August 2014 provider directory for Los Angeles County, we identified errors in the information for 11 providers, or 11.8 percent of the 93 providers we reviewed. Health Net's Medicaid compliance manager told us that it has taken steps to support consistent implementation of its verification process, including holding meetings with the regional team to review the process; providing clarity on steps and responsibilities; increasing oversight, management, tracking, and monitoring; as well as process improvement activities.

Finally, the third health plan we reviewed—Anthem Blue Cross—only recently began actively reaching out to providers to update their information. Anthem Blue Cross's director of business integration and contract administration (director) stated that beginning in the second quarter of 2014, it reached out to a large number of its commercial providers, who also often participate in Medi-Cal, to update the health plan's provider directory information. However, we identified a large number of inaccuracies in Anthem Blue Cross's October 2014 provider directory for Fresno County. Overall, we found one or more inaccuracies in provider information for 18, or 23.4 percent, of the 77 providers we reviewed. For example, three of the providers we reviewed reported to us that they had stopped accepting Anthem Blue Cross's Medi-Cal managed care insurance in July 2014. According to the director, the processes that the health plan uses to verify

We identified a large number of inaccuracies in Anthem Blue Cross's October 2014 provider directory for Fresno County.

the accuracy of the provider directories are consistent across all counties. She stated that Anthem Blue Cross has 2,367 primary care physicians in its provider network for the 28 counties in which the health plan serves Medi-Cal beneficiaries.

The director stated that Anthem Blue Cross began a new process in the second quarter of 2014 to reach out to a selection of its providers to confirm their provider directory information. She reported that Anthem Blue Cross reached out to almost 40,000 providers participating in its commercial provider network, many of whom often participate in Anthem Blue Cross's provider network for Medi-Cal. The director further stated that Anthem Blue Cross had implemented two additional processes during the fourth quarter of 2014. The first process involves mining data from different databases to capture provider demographic changes reported through claims, grievance, and appeals processes. In the second process, the plan reaches out to its contracted medical groups asking them to validate demographic information, provider rosters, and the groups' ability to accept new Medi-Cal managed care beneficiaries. The director stated that Anthem Blue Cross plans to perform these three new processes twice each year to coincide with Health Care Services' requirement to update provider directories twice each year.

Health Care Services' Process for Verifying the Accuracy of Provider Directories Is Inadequate

Although we found multiple errors in the provider directories for both Anthem Blue Cross and Health Net, Health Care Services—which stated that it reviewed the provider directories of the three health plans we examined—did not identify any inaccuracies.

Although we found multiple errors in the provider directories for both Anthem Blue Cross and Health Net, Health Care Services—which stated that it reviewed the provider directories of the three health plans we examined—did not identify any inaccuracies. State law requires Health Care Services to ensure that certain health plans are able to maintain accurate information about a provider's ability to accept new patients enrolled in Medi-Cal managed care. Health Care Services' policy requires plans to submit provider directories for its approval every six months, and one of the goals of the policy is to assure that provider directories contain appropriate, accurate, and complete information. Such information enables each enrollee to obtain a primary care provider without unnecessary delay.

Health Care Services has not ensured that staff follow a consistent methodology for selecting the number of providers to review and for verifying the accuracy of the health plans' directories. Health Care Services' directory review tool, which guides its review of the accuracy of provider directories that health plans submit for approval, is inadequate. Specifically, the tool guides staff who review the directories for the required format and content. However, the

tool does not include guidance on selecting an appropriate sample of providers to review. A Medi-Cal Managed Care section chief (section chief) at Health Care Services told us that staff generally review the lesser of 25 providers or 10 percent of all providers included in the directories that staff approve. However, the practice varies among the staff reviewing directories covering different health plans. For example, Health Care Services confirmed that staff reviewed 25 of the providers listed in Anthem Blue Cross's Fresno County directory and 10 percent of providers in Partnership HealthPlan's Solano County directory. In contrast, the contract manager responsible for conducting the review of Health Net's August 2014 Medi-Cal provider directory for Los Angeles County confirmed that she reviewed 5 percent of the providers listed, or well over 100 primary care providers.

Additionally, Health Care Services does not require staff to use a consistent methodology for sample selection to ensure that they review a sufficient variety of providers to determine whether the health plans' directories are accurate. According to the section chief, some staff members pick one to three providers in a particular specialty—such as pediatrics—from each city listed in the directory under their review. The section chief noted that other staff pick a number, such as 12, and select every 12th provider listed in the directory. Still other staff members choose odd- or even-numbered pages and randomly select variable numbers and types of providers listed on those pages. Because the goal of Health Care Services' review of provider directories is to ensure accuracy and completeness of the entire directory, we expected Health Care Services to use a consistent, statistically valid random sample like the one we used in our survey of providers. When Health Care Services does not require its staff to use a statistically valid random sample, it has less assurance that it is identifying effectively the extent to which errors exist in the provider directories that it reviews.

Health Care Services also could not demonstrate that it performed reviews to verify the accuracy of the three provider directories we reviewed. Although Health Care Services claimed that it did not identify errors in these provider directories, when we asked Health Care Services for the documentation of its reviews, the section chief stated that his staff did not retain this documentation. For example, on December 23, 2014, in response to our request for documentation, the section chief informed us that his staff had reviewed Anthem Blue Cross's October 2014 provider directory that same day. However, he stated that his staff did not keep any documentation of the review. The acting chief confirmed that Health Care Services maintains only the documentation associated with errors it identifies during its reviews of provider directories. Because Health Care Services did not identify any errors in

Additionally, Health Care Services does not require staff to use a consistent methodology for sample selection to ensure that they review a sufficient variety of providers to determine whether the health plans' directories are accurate.

the provider directories we reviewed, it did not maintain any documentation associated with its reviews. The acting chief further stated that the reason staff did not retain documentation associated with their reviews is that there is no requirement to do so. However, we believe that it would be a good business practice for Health Care Services to require staff to document provider directory reviews and to guide them in the review process so that the department can demonstrate its oversight efforts.

Further, Health Care Services did not always maintain documentation for its approvals of those directories. Specifically, for two of the health plans we reviewed, Health Care Services could not provide documentation of its communications with the health plans regarding its provider directory approval. In these instances, we obtained the documentation of approval communications directly from the health plans. According to the acting chief, Health Care Services did not maintain these communications because it is not required to do so. Whether maintaining evidence of provider directory approvals is required or not, we believe that doing so would be a good business practice for Health Care Services.

When health plans' provider directories contain inaccurate information, Medi-Cal managed care beneficiaries may experience difficulties in obtaining timely access to care.

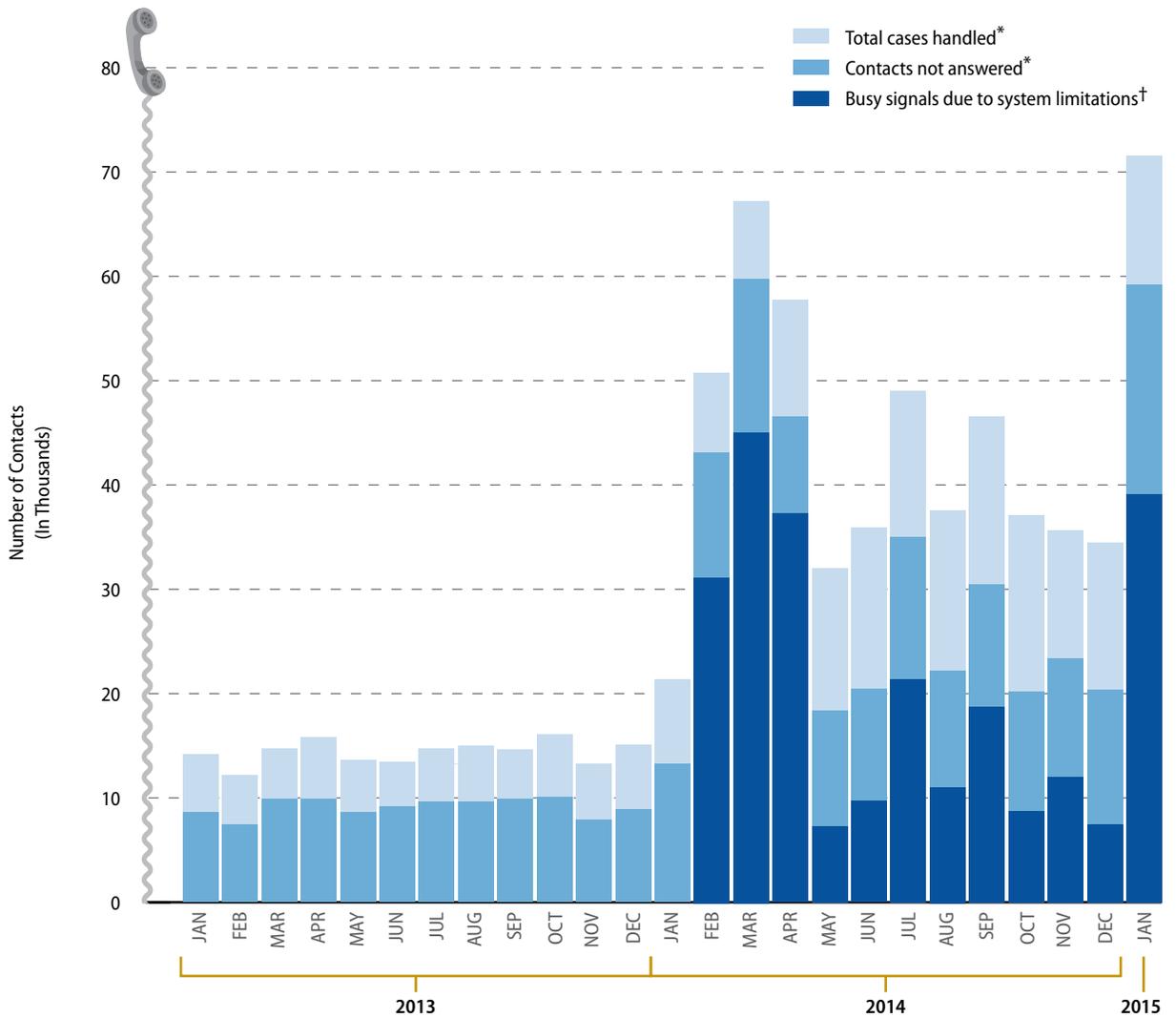
When health plans' provider directories contain inaccurate information, Medi-Cal managed care beneficiaries may experience difficulties in obtaining timely access to care. For example, beneficiaries may not be able to contact providers, or beneficiaries may show up at the wrong locations, causing delays in their receiving medical care. Health plans may also assign beneficiaries to providers who are listed as accepting new patients when, in fact, the providers are closed to new patients. This situation may result in Medi-Cal beneficiaries' inability to get timely appointments with providers. Further, the fact that 4.5 percent of the Anthem Blue Cross providers whose directory listings we reviewed were no longer accepting Medi-Cal insurance raises a question as to whether the size of Anthem Blue Cross's provider network is overstated. Health Care Services agreed that it can enhance its processes to better identify and correct directory inaccuracies.

Health Care Services Cited a Lack of Resources for Its Inability to Respond to All Inquiries or Requests for Assistance From Medi-Cal Beneficiaries

According to the chief of Health Care Services' Medi-Cal Managed Care Office of the Ombudsman (ombudsman chief), the office has lacked adequate resources to handle all the telephone calls it receives from Medi-Cal beneficiaries. As Figure 3 shows, between February 2014 and January 2015 the telephone system for the Medi-Cal Managed Care Office of the Ombudsman (ombudsman office) gave busy signals to callers, rejecting from about 7,000 to

more than 45,000 calls per month. During this period, an average of 12,500 additional calls also went unanswered each month because of staffing limitations. Moreover, the Managed Care Internal Operations Branch chief stated that when the telephone system and the staff were able to answer calls, the ombudsman office lacked an adequate database to track those calls.

Figure 3
Number of Contacts From January 2013 Through January 2015 That the California Department of Health Care Services Received



Source: Call center data from the California Department of Health Care Services' (Health Care Services) California Medical Assistance Program Managed Care Office of the Ombudsman (ombudsman office).

Note: Please refer to the Introduction's *Scope and Methodology* for our assessment of the reliability of data used to create this figure.

* In addition to telephone calls, contacts and cases after July 2014 include email contacts that the ombudsman office received. The ombudsman office estimates that 5 percent of contacts came from these emails.

† According to the phone service provider for Health Care Services, the phone service could not provide information on busy signals before February 2014.

Many Medi-Cal beneficiaries calling the managed care ombudsman office for assistance cannot get through the telephone system to speak with ombudsman office staff.

State regulation allows Health Care Services to designate a Medi-Cal managed care ombudsman who investigates and resolves complaints about managed care plans by or on behalf of Medi-Cal beneficiaries. Some of the calls that the ombudsman office receives include calls from Medi-Cal beneficiaries who have concerns related to their access to health care or complaints regarding the services provided by the health plan. However, according to the ombudsman office's staff, the office's telephone system cannot handle the volume of calls that the ombudsman office receives. Specifically, the ombudsman chief provided data showing that the ombudsman office receives anywhere from 32,000 to more than 71,000 calls for assistance each month. She stated that the telephone system can handle only 25,000 calls per month. As a result, many callers cannot get through the telephone system to speak with ombudsman office staff. The acting chief stated that Health Care Services is in the final phases of upgrading its telephone system for the ombudsman office, with full implementation expected by June 30, 2015. He stated that the new telephone system will not limit the number of telephone calls that the ombudsman office can receive each month. Further, the new system will have an automated system to route the caller to the proper analyst by using a combination of factors, including the agent's availability to accept calls and the agent's skill level. He stated that the system will also have a queuing function that can prioritize calls based on their time in the queue.

Moreover, the ombudsman chief stated that the ombudsman office's staffing limitations have led it to answer an average of only 30 percent to 50 percent of the calls that the telephone system has accepted. She stated that although calls that go unanswered within 18 minutes' wait time are directed to a voicemail service, the ombudsman office lacks staffing capacity to answer these messages. The ombudsman chief noted that the office does not know whether the calls that the telephone system does not accept or that staff cannot answer correspond to new cases that never get addressed or are associated with multiple repeat calls by limited numbers of individuals for cases that the ombudsman office eventually handles and resolves. Figure 3 on the previous page depicts the monthly discrepancies between the numbers of phone calls placed to the ombudsman office's call center and the numbers of calls answered from January 2013 through January 2015.

According to the chief of the Managed Care Internal Operations Branch, in addition to limitations of the telephone system and staff, the ombudsman office has lacked an adequate database to track all calls that its staff are able to answer. Specifically, he stated that the staff have maintained in a database the information related to all calls answered. Health Care Services' management has reviewed these data periodically to identify trends specifically related to the

resolution of the calls in order to train staff regarding current issues. However, the ombudsman chief stated that because of hardware limitations, the database has crashed frequently, resulting in loss of data related to the contacts the staff may be addressing at the time. She further indicated that the ombudsman office's practice has been for the analyst to attempt to reenter the information that was lost during a system crash to minimize the amount of information that is lost. The chief of Managed Care Internal Operations Branch estimated that the database has lost information related to 10 to 20 calls each month. The ombudsman chief also stated that Health Care Services was in the process of upgrading the database to ensure data integrity, and the acting chief stated that Health Care Services upgraded its server software in March 2015 and plans to have an updated system in place during fiscal year 2015–16.

The ombudsman chief stated that because of hardware limitations, the database has crashed frequently, resulting in loss of data related to the contacts that staff may be addressing at the time.

Health Care Services Needs to Improve Its Monitoring of Health Plans

Health Care Services has not monitored health plans adequately to ensure that they meet Medi-Cal beneficiaries' medical needs. Specifically, Health Care Services has not performed, as required by state law, annual medical audits of all Medi-Cal health plans to evaluate the overall performance of the health plans in providing health care benefits to enrollees. Also, Health Care Services has not always ensured that Managed Health Care has performed all the required quarterly assessments that it contracted to provide. As a result, Health Care Services cannot verify adequately that health plans are ensuring that Medi-Cal beneficiaries have adequate access to care.

Health Care Services Has Not Completed Annual Medical Audits of Health Plans as State Law Requires

Health Care Services has not complied with a statutory requirement to perform annual medical audits of Medi-Cal health plans. Specifically, state law requires Health Care Services to perform annual medical audits of all Medi-Cal health plans to evaluate the overall performance of the health plans in providing health care benefits to their enrollees. However, according to the chief of Health Care Services' Medical Review Branch, Health Care Services did not perform any annual medical audits before 2012. He stated that he was advised of the legal requirement for annual medical audits once he assumed the position of chief in May 2011, and he immediately began addressing the issue. Specifically, he stated that he began assembling audit staff capable of performing the annual medical audits, and this effort included redirecting approximately 40 percent of existing staff and training them.

Health Care Services performed medical audits of only five health plans in fiscal year 2012–13, 10 health plans in fiscal year 2013–14, and—as of May 2015—nine health plans in fiscal year 2014–15.

As staff completed training, they were able to perform some of the annual medical audits. Nonetheless, Health Care Services has not yet fully complied with the statutory requirement for annual medical audits. Specifically, Health Care Services contracts with 21 health plans during fiscal year 2012–13, and it contracted with one additional health plan during fiscal year 2013–14 to raise the number to 22 health plans. However, Health Care Services performed medical audits of only five health plans in fiscal year 2012–13, 10 health plans in fiscal year 2013–14, and—as of May 2015—nine health plans in fiscal year 2014–15. Therefore, Health Care Services has not ensured that all health plans are complying with the provisions of their contracts to provide Medi-Cal beneficiaries proper access to health care.

According to the chief of the Medical Review Branch, as of May 2015, his unit had six audit teams, each consisting of two medical consultants, two nurses, and two auditors. The audit teams also included one pharmacist, if available. He stated that all teams were fully trained and ready to meet the annual audit requirement. Further, he stated that his branch was in the process of developing a schedule of audits to be performed over the next fiscal year and that the goal is to fully meet the statutory annual audit requirement in fiscal year 2015–16.

Delays in Executing an Agreement Prevented Managed Health Care From Performing All Quarterly Assessments of Health Plans’ Provider Networks

Managed Health Care did not perform the quarterly assessments of provider network adequacy required under an agreement with Health Care Services. When these assessments are not completed, the State cannot be certain that the health plans are maintaining adequate provider networks to serve Medi-Cal beneficiaries. The State has established patient access standards for health plans’ provider networks through regulations and contract provisions. In accordance with state law, Health Care Services enters into an agreement with Managed Health Care to review provider networks. As the Introduction discusses, Health Care Services entered into two agreements with Managed Health Care to perform quarterly reviews of provider network adequacy. The first agreement, signed in 2011, involved performing these assessments for the 30 counties that were participating in Medi-Cal managed care at the time. The second agreement, signed in 2014, was for assessments for 28 additional counties after Medi-Cal managed care expanded to rural counties. Although Managed Health Care confirmed that it assessed health plans serving all counties for the first quarter of 2014, since then it has been unable to perform the assessments of health plans serving the 28 counties that were part of the expansion

of Medi-Cal managed care to rural counties. The health plans in these counties had a total Medi-Cal enrollment of nearly 351,000 as of March 2014 and more than 515,000 in March 2015.

Although the Legislature approved four limited-term positions in June 2013 for July 2013 through December 2014, Managed Health Care stated that it did not fill these positions before their expiration in December 2014. The Legislature approved these positions for Managed Health Care to conduct adequacy assessments of provider networks for the Healthy Families Program's transition to Medi-Cal. According to the deputy director of Managed Health Care's Office of Plan Licensing (licensing chief), the work performed for the transition was very similar to the work required under the agreement with Health Care Services. Therefore, Managed Health Care planned to use these same positions to perform the work outlined in the agreement. She stated that Managed Health Care waited to fill the positions until the agreement was signed. However, the departments did not sign this agreement until May 2014, and the California Department of General Services did not approve it until June 2014. At that point, according to the licensing chief, Managed Health Care decided not to spend resources trying to fill the limited-term positions, given their impending expiration. Instead, its existing staff performed the reviews for the first quarter of 2014, but Managed Health Care determined that it could not sustain that amount of additional work. According to a senior attorney in the Office of Plan Licensing, the delays in executing the agreement were caused by several factors, such as multiple changes in the scope of the agreement, which resulted in additional reviews by Managed Health Care and Health Care Services' Contract Management Unit. However, the licensing chief stated that because of a recent increase in staffing levels, as of May 2015, Managed Health Care plans to resume soon the quarterly reviews for all counties, beginning with reviews for the first quarter of 2015.

Although the Legislature approved four limited-term positions in June 2013 for July 2013 through December 2014, Managed Health Care stated that it did not fill these positions before their expiration in December 2014.

Managed Health Care Has an Opportunity to More Efficiently Fulfill Some of Its Monitoring Responsibilities That Overlap With Health Care Services

Both Managed Health Care and Health Care Services perform periodic reviews and audits of Medi-Cal health plans using the standards established under the Knox-Keene Act. Health Care Services must perform its audits of health plans more frequently than the reviews that Managed Health Care is required to perform. Therefore, we believe that Managed Health Care should rely on some of the work that Health Care Services performs as part of its audits.

State law requires Managed Health Care to review at least once every three years all of the health plans it licenses, which include 17 of the 22 health plans for Medi-Cal managed care.

State laws require both Health Care Services and Managed Health Care to perform periodic reviews of many health plans, including health plans for Medi-Cal managed care. Specifically, state law requires Health Care Services to perform annual medical audits of each health plan for Medi-Cal managed care to determine, among other things, the health plans' ability to provide quality health care services and to assess the overall performance of the health plans in providing health care benefits to their enrollees. Another state law requires Managed Health Care to review at least once every three years all of the health plans it licenses, which include 17 of the 22 health plans for Medi-Cal managed care. Managed Health Care's review must include evaluations of the plans' internal procedures for assuring quality of care and the overall performance of the plans in providing health care benefits and meeting the health needs of the enrollees.

As Table 5 shows, the two departments' reviews include many overlapping areas. For example, both Health Care Services and Managed Health Care review whether each health plan ensures that services are accessible and available to enrollees within reasonable time frames and whether each health plan resolves all grievances and appeals in a professional, fair, and timely manner. In fact, Managed Health Care reviews only one area that Health Care Services does not review. Specifically, Managed Health Care reviews whether each health plan has implemented a language assistance program to ensure that interpretation and translation services are accessible and available to enrollees. Similarly, Health Care Services reviews one area that Managed Health Care does not. Health Care Services analyzes the administrative capacity and organizational structure of each health plan to make certain that it has both a full-time medical director and a program in place to identify instances of fraud and abuse. Nevertheless, the two departments' reviews overlap in seven areas.

Although the two departments stated that they coordinate their efforts to a certain extent, the coordination focuses on minimizing their impact on the health plan. Specifically, staff from the two departments meet periodically to discuss the time frames for reviewing a health plan to ensure that they coordinate the timing of their reviews. According to the chief of Health Care Services' Medical Review Branch, the two departments also coordinate their efforts to eliminate contradictions in their reports.

However, given the overlapping focus of the two departments' reviews, Managed Health Care has an opportunity to reduce or eliminate duplication of work. State laws allow the two departments to rely on each other's work to meet the statutory requirement, but neither department has done so. Because Health Care Services must review the 22 Medi-Cal health plans more frequently

than Managed Health Care, we believe that for the 17 Medi-Cal health plans that it licenses, Managed Health Care should rely on Health Care Services' reviews for information that falls under the review areas that overlap. This practice will allow Managed Health Care to focus its reviews of these health plans on the limited areas that Health Care Services does not review.

Table 5
Areas of California Medical Assistance Program Managed Care Health Plans Reviewed by the California Departments of Health Care Services and Managed Health Care

AREA OF REVIEW	DESCRIPTION OF REVIEW	CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (HEALTH CARE SERVICES)	CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (MANAGED HEALTH CARE)
Utilization Management	Whether a California Medical Assistance Program (Medi-Cal) managed care health plan (health plan) manages the utilization of services through a variety of cost-containment mechanisms while ensuring access and quality care.	●	●
Access and Availability of Services	Whether a health plan ensures that its services are accessible and available to enrollees throughout its service areas within reasonable time frames.	●	●
Quality Management	Whether a health plan assesses and improves the quality of care it provides to its enrollees.	●	●
Grievances and Appeals	Whether a health plan resolves all grievances and appeals in a professional, fair, and expeditious manner.	●	●
Case Management and Coordination of Care	Whether a health plan ensures that services are furnished in a manner providing continuity and coordination of care and ready referral of patients to other providers consistent with good professional practice.	●	●
Administrative and Organizational Capacity	Whether a health plan has the administrative capacity and organizational structure to ensure compliance with contractual responsibilities, to ensure an independent medical decision-making process, and take appropriate corrective action against fraud, abuse, or both in the provision of health services under the Medi-Cal program.	●	✗
Language Assistance	Whether a health plan implements a language assistance program to ensure that interpretation and translation services are accessible and available to enrollees.	✗	●
Access to Emergency Services and Payment*	Whether a health plan ensures that emergency services are accessible and available and that timely authorization mechanisms are provided for medically necessary care.	●	●
Prescription Drugs*	Whether a health plan that provides prescription drug benefits maintains an expeditious authorization process for prescriptions and ensures benefit coverage is communicated to enrollees.	●	●

Sources: The website for Managed Health Care, a division overview document from Health Care Services, and the chief of the Medical Review Branch at Health Care Services.

● = Reviewed.

✗ = Not reviewed.

* Health Care Services reviews these areas as part of the *access and availability of services* component of its review.

As stated earlier, Health Care Services began performing the required annual audits of health plans in 2012. Although Managed Health Care does not rely on the work performed by Health Care Services, the two departments have been coordinating since 2013 to minimize duplication of work. The deputy director of Managed Health Care's Help Center stated that although Managed Health Care does not rely on the work performed by Health Care Services, the two departments are presently sharing audit tools, coordinating survey logistics, and sharing audit findings and corrective actions to minimize the amount of duplication that occurs. However, Managed Health Care can further reduce and potentially eliminate overlapping reviews of health plans by using, to the extent possible, the work performed by Health Care Services during its annual audits to fulfill Managed Health Care's review requirement. The deputy director also stated that Managed Health Care is analyzing methods to use work performed during Health Care Services' audits to meet the legal requirements for its future reviews of Medi-Cal managed care plans. He stated that Managed Health Care will assess Health Care Services' annual audit processes and findings to better understand its methodologies before determining to what extent Managed Health Care can rely on Health Care Services' work.

Recommendations

To ensure that Health Care Services accurately analyzes the adequacy of provider networks when initially certifying a health plan and when new beneficiary populations are added, it should establish by September 2015 a process to verify the accuracy of the provider network data that it uses to determine if a health plan meets adequacy standards for provider networks.

To make certain that it can provide support for its review process related to the adequacy of provider networks, Health Care Services should maintain for three years all documentation that supports its provider network certifications.

To ensure that Managed Health Care reaches accurate conclusions during its quarterly assessments of the adequacy of provider networks, Health Care Services should establish by September 2015 a process to verify the accuracy of the provider network data it receives from health plans and forwards to Managed Health Care. For example, Health Care Services could verify, for a sample of physicians claimed as part of the health plans' provider networks, that health plans have current written agreements with the providers.

To improve the accuracy of provider directories, by December 2015 Health Care Services should revise its processes for monitoring health plans' provider directories. Specifically, Health Care Services should review how each health plan updates and verifies the accuracy of the directory. In addition, Health Care Services should identify best practices and require the plans to adopt those practices.

To ensure that its review of provider directories is effective in identifying inaccurate information before it approves them for publication, Health Care Services should establish by September 2015 more detailed written policies and procedures for staff to follow that will provide evidence that staff are verifying the accuracy of provider directories. This verification process should include, at a minimum, the following elements:

- Developing a standard process for selecting a random sample, including procedures for selecting a sample size that is sufficient to identify errors in a provider directory and to enable Health Care Services to understand the accuracy of the entire directory. Health Care Services should then ensure that staff follow this process.
- Requiring staff to maintain for at least three years the documentation of their reviews and the verifications of the accuracy of provider directories.
- Retaining for three years Health Care Services' communications with the health plans about any errors found in the directories or about the approvals of the directories.

If Health Care Services finds significant errors in a health plan's provider directory, it should work with that health plan to identify reasons for the inaccuracies and require the health plan to develop processes to eliminate the inaccuracies.

To ensure that it can handle adequately the volume of calls from Medi-Cal beneficiaries, Health Care Services should implement an effective plan to upgrade or replace its telephone system and database to make certain that its ombudsman office can handle the volume of calls and maintain complete data to make informed management decisions. Further, after upgrading or replacing its systems, if Health Care Services believes that it does not have adequate staffing to address workload, it should justify its need and request additional staff.

To make certain that Health Care Services complies with state law requiring it to conduct annual medical audits, it should finish developing and begin adhering to its schedule for auditing all health plans in fiscal year 2015–16.

To ensure that Health Care Services complies with state law, it should increase its oversight of Managed Health Care to ensure that it completes the quarterly assessments required under the agreements. To make certain that Managed Health Care complies with its contractual obligations, it should continue its plan to perform quarterly reviews of the adequacy of provider networks beginning with the first quarter of 2015. Managed Health Care should monitor workload closely, and it should justify and request additional staff if it determines it does not have adequate staffing to perform quarterly reviews.

To increase the efficiency of statutorily required reviews by eliminating duplicative work, Managed Health Care should complete by September 2015 its planned assessment of the extent to which it can rely on Health Care Services' annual audits. If it determines that Health Care Services' work is sufficient to meet Managed Health Care's responsibility under the Knox-Keene Act, it should coordinate with Health Care Services to eliminate the duplication of work.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code 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 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,



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State Auditor

Date: June 16, 2015

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Appendix A

CALIFORNIA STATE AUDITOR'S TELEPHONE SURVEY OF PRIMARY CARE PROVIDERS IN THREE CALIFORNIA MEDICAL ASSISTANCE PROGRAM MANAGED CARE HEALTH PLANS

To determine the accuracy of information included in provider directories for the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans), we selected for review the latest provider directories approved by the California Department of Health Care Services (Health Care Services) in 2014 for three health plans that serve Medi-Cal beneficiaries. Specifically, we reviewed the accuracy of provider listings for primary care physicians in the October 2014 Anthem Blue Cross provider directory for Fresno County, the August 2014 Health Net provider directory for Los Angeles County, and the July 2014 Partnership HealthPlan of California (Partnership HealthPlan) provider directory for Solano County.⁶ As the Introduction discusses, a health plan makes its provider directory available to enrollees to assist them in making informed decisions when selecting their primary care physicians. Therefore, we limited our review to primary care physicians.

We randomly selected a statistically valid number of primary care physicians from each provider directory. Specifically, we consulted with a statistician to determine the appropriate sample size based on the total number of primary care providers included in each directory so that we could be 95 percent confident of our results. Because the directories of the three health plans had varying numbers of providers, the number of providers we surveyed differed for each health plan. We selected and called 77 of the 383 primary care providers listed in the Anthem Blue Cross directory for Fresno County, 93 of the 2,468 primary care providers listed in the Health Net directory for Los Angeles County, and 32 of the 47 primary care providers listed in the Partnership HealthPlan directory for Solano County. We contacted each provider's office and asked the five questions shown in Table A on the following page as well as any appropriate clarifying questions. If the listed telephone number for the provider was incorrect, we made a note of that error and tried to identify through Internet research the correct telephone number for the provider. If the answers to the survey questions indicated inaccuracies regarding information in a provider directory, we consulted the appropriate health plan's website to determine whether the health plan had updated the

⁶ These are the months and years that the health plans completed their directory updates. Health Care Services' review and approval of the directories occurred later.

information in its online directory subsequent to publishing the printed version of the provider directory. We discuss the results of our survey in the Audit Results.

Table A

Telephone Survey Questions We Asked a Sample of Primary Care Providers for the Three California Medical Assistance Program Managed Care Health Plans That We Reviewed

TELEPHONE SURVEY QUESTIONS

1. Is this the office of [PROVIDER NAME]?

If not the correct provider office, ask "Has this provider ever worked at your location?"

If "No," note that phone number listed was incorrect and end the call.

If "Yes," ask, "When did the provider stop working at this location?"

Ask questions 2 and 3 only.

2. What is your address?

If different from the listing, record the correct address and ask, "Has the office moved recently?"

3. What is the type of medical practice—such as pediatrics or internal medicine—of [PROVIDER NAME]?

If unknown, conduct rest of survey but ask at the end for contact for missing information.

4. Does [PROVIDER NAME] accept Medi-Cal managed care coverage through [HEALTH PLAN NAME]?

If unknown, conduct rest of survey but ask at the end for contact for missing information.

If "No," ask, "Has the provider ever accepted Medi-Cal managed care coverage through [HEALTH PLAN NAME]?"

If "No," end the call.

If "Yes," ask, "When did you stop accepting this coverage?" Then end the call.

5. Is [PROVIDER NAME] [ACCEPTING or CLOSED TO] new patients with Medi-Cal coverage?

If unknown, ask for contact for this information.

If "No," ask, "When did you [START or STOP] accepting new Medi-Cal patients with this coverage?" Then end the call.

Source: California State Auditor's script for the telephone survey of selected primary care providers for three California Medical Assistance Program managed care health plans.

Appendix B

CALIFORNIA MEDICAL ASSISTANCE PROGRAM MANAGED CARE HEALTH PLANS' PROCESSES FOR MONITORING THEIR PROVIDER NETWORKS

In early 2015 we visited Anthem Blue Cross, Health Net, and Partnership HealthPlan of California—which offer the California Medical Assistance Program (Medi-Cal) managed care health plans (health plans)—and reviewed the processes each employs to ensure that it provides beneficiaries with access to medical care and necessary assistance and that it recruits and retains appropriate providers. State regulations under the Knox-Keene Health Care Service Plan Act of 1975 require all managed care health plans in California to ensure that their enrollees have access to quality medical care. Specifically, state regulations require health plans to ensure that services are readily available and accessible at reasonable times to each enrollee. To provide available and accessible services to their members, health plans must recruit and retain medical providers. We found that the three health plans employ similar processes. For example, each of the three health plans we reviewed has formal and informal processes to assist beneficiaries with locating providers. Further, all three health plans employ similar processes for recruiting primary care physicians to their provider networks and for retaining those providers. Table B on the following page shows actions taken by health plans to ensure access and assistance to members, as well as for provider recruitment and retention.

Table B
Summary of Actions by Selected California Medical Assistance Program Managed Care Health Plans to Ensure Member Access and Assistance, as Well as Provider Recruitment and Retention

OVERSIGHT AREA	ACTIONS	CALIFORNIA MEDICAL ASSISTANCE PROGRAM (MEDI-CAL) MANAGED CARE HEALTH PLAN (HEALTH PLAN)		
		ANTHEM BLUE CROSS	HEALTH NET	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP HEALTHPLAN)
Ensuring that Medi-Cal beneficiaries have adequate access to providers	Review network adequacy at least annually, including the following components:			
	• Beneficiary-to-provider distance	●	●	●
	• Beneficiary-to-provider ratio	●	●	●
	• Percent of providers open to new patients	●	●	●
	• Grievance trends related to beneficiaries access to care	●	●	●
Assisting Medi-Cal beneficiaries who have trouble locating a provider	• Wait time to see providers	●	●	●
	Operate a call center to respond to member complaints and aim to resolve issues within 24 hours.	●	●	●
Ensuring provider recruitment and retention	Maintain a formal grievance process and resolve grievances within 30 days, as required by the contract with the State.	●	●	●
	Identify shortages of key specialists.	●	●	●
	Maintain a provider relations unit and regional offices to assist in provider recruitment and retention.	●	●	●
	Reach out to and encourage all Medi-Cal fee-for-service providers to participate in its network.	NA*	NA [†]	●
	Provide financial support to participating medical groups for their recruiting efforts.	✗	● [‡]	●
	Reach out to all specialists in service area and encourage them to participate in its network.	● [§]	NA [†]	●
	Contract with specialists, even when they refuse Medi-Cal reimbursement rates.	NA	● [‡]	●
	Maintain a dedicated help line to resolve problems that providers may encounter.	●	●	●
	Provide education and training for providers and their staff to adapt to new processes implemented by the health plan.	●	●	●
	Provide incentive programs and performance bonuses to providers.	●	● [‡]	●
	Use automatically renewing contracts with providers.	● [#]	●	●
Conduct annual satisfaction survey of providers to identify and address provider concerns.	●	●	●	

Sources: California State Auditor's analysis of interviews with key managers at Anthem Blue Cross, Health Net, and Partnership HealthPlan and supporting documentation.

NA = Not applicable

● = Action taken

✗ = No action taken

* The regional vice president for provider engagement and contracting for Anthem Blue Cross reported that in Fresno County, Anthem Blue Cross uses a delegated model and has no direct outreach to primary care providers. Instead, Anthem Blue Cross relies on medical groups to maintain an adequate network of primary care physicians in Fresno County.

† Health Net's Medi-Cal compliance manager reported that in Los Angeles County it uses a delegated model and has no direct outreach to providers. Instead, staff reported that Health Net relies on medical groups to maintain an adequate network of physicians.

‡ Health Net's director of compliance and Medi-Cal compliance officer noted that Health Net performs these actions subject to specific circumstances.

§ Anthem Blue Cross's director of business integration and contract administration (contract director) noted that Anthem Blue Cross reaches out to needed specialists in its service area and encourages them to participate in its network.

|| Anthem Blue Cross's contract director will enter into single-case agreements with providers with respect to continuity of care and allowing access to hard-to-find specialists.

Anthem Blue Cross's provider agreements do not include a termination date.

June 2015



JENNIFER KENT
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

May 27, 2015

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, *California Department of Health Care Services Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care*.

Although the CSA conducted this audit and issued several findings, DHCS only partially agrees with them. Prior to the commencement of the audit, DHCS had already begun developing and enhancing various network monitoring and certification processes. Significant work had occurred to identify areas of concern and next steps were determined. ①

In November of 2014, DHCS completed a reorganization of the Medi-Cal Managed Care Division into two new Divisions: 1) the Managed Care Operations, and 2) the Managed Care Quality and Monitoring. The purpose of the reorganization was to align operations and oversight of the Medi-Cal managed care program within DHCS with the rapidly increasing managed care enrollment – both as a percent of the whole and numerically. This split has allowed the two Divisions to specialize respectively in operations and quality and monitoring – in particular in the areas of network certifications, monitoring, and adequacy. A Network Adequacy and Monitoring Units were established within DHCS to specifically focus on and call out these efforts.

Currently, DHCS has a process for approving provider directories and certifying and monitoring health plan networks. The CSA audit focused on some portions of the network certification and monitoring processes. However, DHCS performs a substantial number of additional network monitoring efforts that were not reviewed as a part of this audit. These monitoring efforts include, but are not limited to, ongoing transition monitoring, grievances and appeals, State Fair Hearings, Independent Medical Reviews, call center/Ombudsman reports, secret shopping, network validation through ②

Ms. Elaine M. Howle
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data usage, timely access verification, and continuity of care data. Various monitoring elements are published in the quarterly Medi-Cal Managed Care Performance Dashboard.

DHCS agrees that certain monitoring processes need to be enhanced and began taking steps to accomplish this well before the audit occurred. DHCS began a Network Adequacy Monitoring Project in 2014 and has made significant progress with implementing new monitoring enhancements. Additionally, DHCS is in the process of certifying all health plan networks for the Behavioral Health Treatment benefit expansion into managed care and has created a formal network assessment tool to assist with this process and assure verification of networks occurs. This tool will be used ongoing.

- ③ For the past three years, DHCS and DMHC have worked together to coordinate medical audits and surveys. This coordination includes conducting bi-weekly audit conference calls, the creation of a coordinated audit schedule, a side-by-side analysis of audit and survey tools, and coordinated health plan corrective action plans, when applicable. Additionally, the audit teams are onsite concurrently, conduct joint interviews, and sampling of procedures and data. DHCS also follows up on network findings concurrently together through joint communications to health plans.

DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Jacqueline Shepherd, Audit Coordinator, at (916) 650-0298.

Sincerely,

Jennifer Kent
Director

cc: Ms. Karen Johnson
Chief Deputy Director
Policy and Program Support
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May 27, 2015

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Attachment

Department of Health Care Services Response to California State Auditor's Report: Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care

Health Care Services Certified Health Plans' Provider Networks Without Verifying the Underlying Provider Network Data.

Recommendation: To ensure it is accurately analyzing the adequacy of provider network when initially certifying a health plan and when new beneficiary populations are added, by September 2015, it should establish a process to verify the accuracy of the provider network data that it uses to determine if a health plan meets network adequacy standards.

① **Response:** DHCS partially agrees with the recommendation.

Currently, DHCS has a process for approving provider directories and certifying and monitoring health plan networks. The CSA audit focused on some portions of the network certification and monitoring processes.

② However, DHCS performs a substantial number of additional network monitoring efforts that were not reviewed as a part of this audit. These monitoring efforts include, but are not limited to, ongoing transition monitoring, grievances and appeals, State Fair Hearings, Independent Medical Reviews, call center/Ombudsman reports, secret shopping, network validation through data usage, timely access verification, and continuity of care data. Various monitoring elements are published in the quarterly Medi-Cal Managed Care Performance Dashboard.

DHCS intends to enhance the current review tool to better document the steps and processes for documenting the review process and retention of working documents. Furthermore, DHCS will determine a methodology to randomly sample the data and verify the accuracy of plan submitted data. DHCS agrees with the September 2015 timeline.

Recommendation: To ensure that it can provide support for its review process related to the adequacy of provider networks, Health Care Services should maintain all documentation that supports its network certifications for three years.

Response: DHCS agrees with the recommendation.

Proper document retention is very important to DHCS. While developing the enhanced review tool and process, DHCS will ensure retention of documentation is for 3 years.

Health Care Services Does Not Verify the Accuracy of the Data Used for the Required Ongoing Provider Network Assessment.

Recommendation: To ensure that Managed Health Care reaches accurate conclusions during its quarterly assessments of the adequacy of provider networks, by September 2015, Health Care Services should establish a process to verify the accuracy of the provider network data it received from health plans and forward to Managed Health Care. For example, Health Care

Attachment

Services could verify, for a sample of physicians claimed as part of the health plan's network of providers, that health plans have current written agreements with the providers.

Response:

DHCS agrees with the recommendation.

DHCS agrees with the audit finding. Currently, DHCS has a process for approving provider directories and certifying and monitoring health plan networks, but had self-identified the need for verifying data in the provider file prior to this audit commencing and has already taken steps to improve the data verification process. A two-step quality check will be implemented through the DHCS Network Adequacy Monitoring Project that is underway. First, provider file data will be submitted through a system that conducts a quality check on the data elements and then DHCS will perform a survey to ensure the provider is contracted with the Medi-Cal managed care health plan.

This project has a projected implementation date of early 2016.

The Three Provider Directories We Reviewed Contained Varying Degrees of Inaccurate Information. Health Plans' Varied Provider Directory Review Processes Likely Account for the Differing Level of Directory Errors.

Recommendation: To improve the accuracy of provider directories, by December 2015, Health Services should revise its processes for monitoring health plans' provider directories. Specifically, Health Care Services should review how each health plan updates and verifies the accuracy of the directory. In addition, Health Care Services should identify best practices and require the plans to adopt those practices.

Response:

DHCS agrees with the recommendation.

Currently, DHCS has a process for approving provider directories and certifying and monitoring health plan networks, but DHCS will enhance the current review tool to better document the steps and processes for documenting the review and retention of working documents. Furthermore, DHCS will determine a methodology to randomly sample the directories and contact providers to confirm accuracy. DHCS agrees with the September 2015 timeline for this component of the recommendation.

DHCS already has a process in place to collaborate with plans to incorporate best operational business practices through an all-plan process of feedback and recommendations before implementing any requirements. DHCS will continue to work with plans and associations to identify best practices for provider directory review and develop contractual requirements to submit to the Centers for Medicare and Medicaid Services (CMS) for review and approval. In order to ensure DHCS, plans, and associations have adequate time to work together and develop a standard that will work across the various models DHCS would look to complete this process and submit requirements to CMS by December 2015.

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Health Care Services' Process for Verifying the Accuracy of Provider Directories is Inadequate.

Recommendation: To ensure that its review of provider directories is effective in identifying inaccurate information before it approves them for publication, by September 2015, Health Care Services should establish more detailed written policies and procedures for staff to follow that will provide evidence that staff are verifying the accuracy of provider directories. This verification process should include, at a minimum, the following elements:

Developing a standard random sample selection process, including selecting a sample size that is sufficient to identify errors in the directory and enable Health Care Services to understand the accuracy of the entire directory, and ensuring that staff follow this process.

Requiring staff to maintain documentation of their reviews and verification of the accuracy of provider directories for at least three years.

Retaining its communications with the health plans about any errors found in the directories or the approval of the directories for three years.

If Health Care Services finds significant errors in a health plan's provider directories, it should work with the health plan to identify reasons for the inaccuracies and require the health plan to develop processes to eliminate the inaccuracies.

Response: DHCS agrees with the recommendation.

Currently, DHCS has a process for approving provider directories and certifying and monitoring health plan networks, but DHCS will enhance the current review tool to better document the steps and processes for documenting the review and retention of working documents. Furthermore, DHCS will determine a methodology to randomly sample the directories and contact providers to confirm accuracy. DHCS agrees with the September 2015 timeline.

DHCS strives to have plans that incorporate best operational business practices through a collaborative all plan process of feedback and recommendations before implementing any requirements. DHCS will continue to work with plans and associations to identify best practices for provider directory review and develop contractual requirements to submit to the Centers for Medicare and Medicaid Services (CMS) for review and approval. In order to ensure DHCS, plans, and associations have adequate time to work together and develop a standard that will work across the various models. DHCS agrees with the December 2015 timeline for this.

Health Care Services Cites a Lack of Resources for its Inability to Respond to all Inquiries or Requests for Assistance

Recommendation: To ensure that it can adequately handle the volume of calls from Medi-Cal beneficiaries, Health Care Services should implement an effective plan to

Attachment

upgrade or replace its telephone and database systems to make certain that its ombudsman office can handle the volume of calls and maintain complete data to make informed management decisions. Further, after upgrading its systems, if Health Care Services believes that it does not have adequate staffing to address workload, it should justify its need and request additional staff.

Response: DHCS partially agrees with the recommendation. ①

DHCS identified this issue prior to this audit and has already purchased a new phone system to further enhance the Ombudsman office abilities. The phone system is currently in development and equipment is on order as of April 2015. DHCS will begin monitoring the new system upon going live and will request additional staff based on the data. DHCS expects the phone system to be operational no later than September 2015. DHCS currently has a pending request with the legislature to secure additional positions in 2015-16.

Finding Health Care Services has not Completed Annual Audits of Health Plans as State Law Requires

Recommendation: To ensure that Health Care Services complies with state law requiring it to conduct annual Medi-Cal audits, it should finish developing and begin adhering to its schedule for auditing all health plans in fiscal year 2015-16.

Response: DHCS partially agrees with the recommendation. ①

DHCS recognized this need prior to the audit and thus has worked collaboratively with the DMHC to create an annual audit calendar in order to effectively utilize resources and leverage existing audit activities, which is scheduled to commence in July 2015. By June 30, 2016, and annually thereafter, the DHCS will be in full compliance with state statute requiring annual medical audits of all managed care plans that have been active for at least one year.

Health Care Services Has Not Always Ensured That Managed Health Care Performed all the Required Quarterly Assessments That it Has Contracted to Provide. As a Result, Health Care Services Cannot Adequately Verify That Health Plans are Ensuring That Medi-Cal Beneficiaries Have Adequate Access to Care

Recommendation: To ensure that Health Care Services complies with state law, it should increase its oversight of Managed Health Care to ensure that it completes the quarterly assessments required under the agreements.

Response: DHCS Disagrees with the recommendation.

DHCS disagrees with the audit finding. DHCS had little to no discussion with the audit team relative to oversight of the interagency agreements. ④

During such a discussion, DHCS would have provided information demonstrating that two separate Units focus on oversight of and work associated with the interagency agreements: 1) the Contract Compliance

Attachment

Unit ensures that DMHC Medical Surveys and subsequent corrective action plans are completed and has a robust tracking tool to ensure these processes occur, and 2) the Managed Care Operations Unit partner's with DMHC to send joint network adequacy letters to the Medi-Cal managed care health plans on a quarterly basis.

No specific information is included in the audit report about DHCS' oversight of the interagency agreements.

Comments

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

To provide clarity and perspective, we are commenting on the California Department of Health Care Services' (Health Care Services) response to our audit. The numbers below correspond to the numbers we placed in the margin of Health Care Services' response.

It is unclear what Health Care Services means when it states that it partially agrees with our findings and recommendations. In its responses to these recommendations, Health Care Services outlines actions that it plans to take to fully implement them.

①

Health Care Services appears to downplay the importance of our finding and recommendation. We reviewed those areas of Health Care Services' monitoring activities that we identified as significant to the scope of our audit, which focused on the adequacy of networks of primary care physicians (provider networks) and the accuracy of provider directories. Specifically, as we discuss on page 20, we reviewed Health Care Services' certifications of three California Medical Assistance Program (Medi-Cal) managed care health plans (health plans) when the State eliminated the Healthy Families Program and moved most of its participants into health plans within Medi-Cal. We also reviewed one initial plan certification that we discuss on page 21. Further, we reviewed quarterly assessments of network adequacy, Health Care Services' process for ensuring the accuracy of provider directories, the processing of complaints and related data by Health Care Services' Medi-Cal Managed Care Office of the Ombudsman, and the completion of the required annual medical audits, which we discuss on pages 23, 30, 34, and 35, respectively. Notwithstanding any other activities that Health Care Services might perform, the fact remains that we identified several areas of needed improvement in its monitoring of health plans to better ensure access to care.

②

We acknowledge on page 38 that Health Care Services and the California Department of Managed Health Care (Managed Health Care) coordinate the timing of their reviews and coordinate their efforts to eliminate contradictions in their reports. We also discuss coordination efforts on page 40. However, as we state on page 38, although state laws allow the two departments to rely on each other's work, neither department has done so. Given the overlapping focus of the two departments' reviews, there is an opportunity to reduce or eliminate duplication of work. We also

③

discuss on pages 38 and 39 why we believe that Managed Health Care should rely on Health Care Services' reviews for information that falls under the review areas that overlap.

④

Health Care Services appears to be confused about our finding and related recommendation. During the audit, we were aware of Health Care Services' oversight of the interagency agreements. In its response, Health Care Services references two units' focus on oversight of and work associated with its agreements with Managed Health Care. The medical surveys, the related corrective action plans, and the tracking tool that Health Care Services cites were not related to the quarterly network adequacy reviews that Managed Health Care performs, and were not significant to the scope of our audit, which focused on the adequacy of provider networks and accuracy of provider directories. Further, we did review the joint efforts of Health Care Services and Managed Health Care to follow up on the results of the quarterly network adequacy reviews that Managed Health Care performed. However, our finding beginning on page 35 and related recommendation focus on the quarterly reviews that Managed Health Care did not perform as required under one of the two agreements between the two departments. Health Care Services is ultimately responsible for ensuring that its contractor provides the required services covered under both its agreements. Therefore, we stand by our recommendation on page 42 that Health Care Services increase its oversight of Managed Health Care to ensure that it completes the quarterly assessments required under the agreements.

June 2015



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

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May 27, 2015

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

Dear Ms. Howle:

Thank you for providing the Department of Managed Health Care (DMHC) with the opportunity to review and respond to the California State Auditor's draft audit report. Attached with this letter for inclusion in the final report is the DMHC's response to the draft report's findings relative to the DMHC.

Sincerely,

A handwritten signature in cursive script that reads "Gabriel Ravel".

Gabriel Ravel
General Counsel
Department of Managed Health Care

Department of Managed Health Care (DMHC) Formal Response to Draft Audit Report Recommendations

Recommendation #1. To ensure that Managed Health Care complies with its contractual obligations, it should continue its plan to perform quarterly reviews of the adequacy of provider networks beginning with the first quarter of 2015. Managed Health Care should monitor workload closely and if it determines it does not have adequate staffing to perform quarterly reviews, it should justify and request additional staff.

Response:

The DMHC agrees with the recommendation and is continuing its plan to perform quarterly reviews.

The DMHC network assessments conducted pursuant to the Interagency Agreement will involve complete reviews of the PCP, specialist, mental health, and hospital networks in the 28 counties. This review will be in addition to the quarterly Medi-Cal network reviews for the 30 original counties it has conducted since 2011, pursuant to its 2011 Interagency Agreement with the DHCS. Although the focus of the 2011 Interagency Agreement was on Seniors and Persons with Disabilities, the DMHC has always included an overall evaluation of the availability of providers and their impact on access for all Medi-Cal enrollees as part of its quarterly assessment. This broader review occurs equally for the 28 additional counties.

In accordance with the DMHC's existing quarterly Medi-Cal network assessment process for the original 30 counties, the network assessments for the additional 28 counties has included, and will continue to include, an evaluation of network capacity and geographic access of each Medi-Cal Managed Care plan in each county. To accomplish this, the DMHC will follow the methodology currently utilized in the quarterly Medi-Cal network review process, as follows:

- Identify primary care and specialist providers' ability to accept new patients, capacity, areas of specialty, and geographic accessibility in accordance with Knox Keene requirements and the DHCS contract standards;
- Analyze detailed provider data to evaluate whether physician extenders add to the capacity of the plans' primary care network;
- Calculate provider-to-enrollee ratios;
- Identify which network providers have admitting privileges with contracted hospitals;
- Evaluate individual health plan grievances and complaints received by the Ombudsman and DMHC related to access to care that may indicate a network inadequacy;

Page 2 of 3

- Review DMHC block transfer data for any potential disruptions to networks due to provider contract terminations;
- Evaluate out-of-network requests to determine any areas of specialty care where members are having difficulties obtaining in-network care; and
- Review quality reports to identify quality issues related to network inadequacies.

In addition to the quarterly network assessments, all Knox-Keene licensed Medi-Cal plans are subject to full network reviews in the event of service area expansions, new license applications, or block transfers. With regard to the 28 counties identified in the State Auditor's report, all Knox-Keene licensed health plans that sought to participate in Medi-Cal Managed Care in those 28 counties were subject to complete DMHC network reviews conducted as a result of the service area expansion and new license application filings required under the Knox Keene Act. Additionally, the DMHC notes that the Medi-Cal plans participating in the 28 counties were also reviewed over the course of the Healthy Families transition to Medi-Cal in 2013, as required under AB 1494. Finally, beginning in 2015, all Medi-Cal networks will also be reviewed annually as required by SB 964. These steps will ensure that the DMHC meets its contractual obligations.

Planned completion date: Review of network data will resume immediately upon receipt of the network data in May 2015.

Recommendation #2. To increase the efficiency of statutorily required reviews by eliminating duplicative work, by September 2015, Managed Health Care should complete its planned assessment of the extent to which it can rely on Health Care Services' annual audits. If it determines that Health Care Services' work is sufficient to meet Managed Health Care's responsibility under the Knox-Keene Health Care Service Plan Act of 1975, it should coordinate with Health Care Services to eliminate the duplication of work.

Response:

The DMHC concurs with this recommendation. Prior to this audit finding, both Departments recognized the need for better collaboration and have begun holding discussions on how to avoid duplication of review efforts.

While the DMHC is statutorily required to conduct its own surveys of Medi-Cal Managed Care Plans, it recognizes the substantial overlap between its survey process and the audits conducted by Health Care Services. Although significant steps have been taken to coordinate the two processes, the DMHC continues to work closely with DHCS to identify areas of overlap and better coordinate to avoid duplication of effort and preserve resources.

Page 3 of 3

Presently, the two Departments meet frequently, as often as every other week, and share audit tools, coordinate survey logistics, and share audit findings and corrective actions. Additionally, the DMHC is committed to fully assessing the work performed by Health Care Services in order to identify all opportunities to incorporate their findings into DMHC's survey process, thereby eliminating the duplicative use of resources.

Planned completion date: September 2015.
