Monitoring Access in the Medi-Cal Program

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Introduction

The federal Centers for Medicare & Medicaid Services (CMS) recently approved a request by the California Department of Health Care Services (DHCS) to extend California's 1115 Medicaid Demonstration Waiver, called the *2020 Demonstration*, effective December 2015 through December 2020.[1] The $6.2 billion demonstration project will fund several programs, including system redesign and payment innovation initiatives, with the goal of strengthening public hospitals and improving care quality for safety net populations.[2]

In the prior iteration of California's Waiver—called the *Bridge to Reform*—CMS allowed California to substantially expand the penetration of managed care into the Medi-Cal program.[3] The *Bridge to Reform* allowed the State to enroll certain Medi-Cal beneficiaries—including seniors and people with disabilities, and beneficiaries in 28 rural counties—into Medi-Cal managed care plans on a mandatory basis.[4] CMS also allowed DHCS to expand voluntary enrollment into Medi-Cal managed care for beneficiaries dually eligible for Medicare in eight counties.[5] In the *2020 Demonstration*, CMS will require DHCS to evaluate the impact of this massive expansion of Medi-Cal managed care on beneficiaries' access to care. DHCS must contract with an outside organization to carry out an independent access assessment for managed care enrollees based on the network adequacy requirements set forth in the California's Knox-Keene Act and Medi-Cal managed care contracts.[6] CMS likely required this evaluation in response to concerns advocates raised during the waiver negotiation process about current Medi-Cal beneficiaries' access to care in Medi-Cal managed care.[7]

An independent assessment of managed care access in Medi-Cal is welcome. When DHCS has monitored access itself, it has not lived up to its obligations.[8] Previously, DHCS promised CMS that it would monitor access to Medi-Cal benefits in fee-for-service Medi-Cal after it cut provider payment rates in 2011.[9] But DHCS has not demonstrated that it has ensured access in Medi-Cal. Advocates will have to watch the new assessment process closely to ensure that it provides a thorough evaluation of access to services in Medi-Cal managed care.

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AB 97 Rate Reductions and Fee-for-Service Access Monitoring

Background

In 2008, the Governor approved a budget that cut payment rates for many fee-for-service Medi-Cal providers by 10% for two years.[10] The cuts required approval by CMS, through a process known as a Medicaid State Plan Amendment (SPA).[11] California submitted a series of SPAs to implement the cuts in 2008, which CMS disapproved on November 18, 2010.[12] CMS disapproved the SPAs because "California has not demonstrated that it would meet the conditions set out in section 1902(a)(30)(A) of the Social Security Act." [13] California requested reconsideration of its SPAs, which was granted on December 21, 2010.[14] After reconsideration, CMS approved the SPAs on October 27, 2011.[15]

While reconsideration of the SPA was pending, in 2011, Governor Brown approved a continuation of the 10% rate reduction for most fee-for-service Medi-Cal providers.[16] California submitted another SPA to implement that reduction, which was also approved on October 27, 2011.[17]

Monitoring requirements have not been met

In the SPA approval letters, CMS took note that California had established a "monitoring plan . . . by which beneficiary access will be monitored on a service-by-service basis for all the services at issue in these three SPAs. We believe that the proposed monitoring process will allow California to ensure that payment rates for 2011 are consistent with section 1902(a)(30)(A) of the Act or to promptly take corrective action if the rates prove to be insufficient. The State will monitor predetermined metrics on a quarterly or annual basis in order to ensure that beneficiary access is comparable to services available to the general population in the geographic area."[18]

The approved SPAs incorporate by reference a separate document containing a monitoring plan.[19] That document sets forth 23 separate areas which DHCS promises to monitor and summarize into an "annual report [that] will focus on the quarterly early warning measures listed above, as well as the remaining 18 access measures. The report will be organized and presented in a thoughtful way, highlighting key findings and tailoring technical information to a general audience." [20]

To date, DHCS has not published a single annual report.[21] It has produced quarterly reports for all of 2013, and Q1 2014, which focus on the four early warning measures: Change in Medi-Cal Enrollment, Provider Participation Rates, Service Rates per 1,000 Member Months, Help Line Calls.[22] In its analysis of the 2014-15 health budget, the Legislative Analyst Office (LAO) was highly critical of the both DHCS's baseline analyses of access to services affected by the cuts in the fee-for-service program prior to the implementation of the AB 97 rate reductions and the quality of the subsequent access monitoring reporting, finding that "while the

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administration has . . . established a fee-for-service monitoring system, the public reporting from this system has been unsuitable for drawing meaningful conclusions about beneficiary access."[23] The LAO also found that in the reports DHCS had produced, the Department relied on estimates of available fee-for-service physicians that were likely inflated, used flawed construction and interpretation of enrollee-to-physician ratios, and failed to provide an adequate explanation for some of its exemption decisions.[24]

It remains unclear whether DHCS is in fact monitoring the 23 criteria set forth in its monitoring plan as there is no public report to offer any evidence of it. To the extent that DHCS is monitoring all of the criteria, it has not demonstrated how it is analyzing them, particularly with respect to the 19 criteria not designated as early warning measures.

California's Medi-Cal 2020 Waiver Managed Care Access Assessment Report

Background

Only the fee-for-service reductions under AB 97 required direct approval from the federal government.[25] As a result, DHCS' baseline analyses and monitoring plan only covered the State's fee-for-service system to meet conditions for federal approval. Reimbursement rates to providers for affected services in the managed care program were also reduced via actuarial equivalent reductions in the capitation payments to managed care plans.[26] Federal approval was not required for these reimbursement cuts, however, and so the DHCS did not carry out any baseline analysis of access or establish a monitoring plan to assess the impact on access of rate reductions in the managed care program.[27]

Noting this gap in the State's attention, the LAO, in its analysis of the impact of the AB 97 payment reductions on access, recommended that, " the Legislature refocus its future oversight priorities on monitoring the managed care system . . . . [T]he state has delegated much *de facto* control over provider payment policy to Medi-Cal managed care plans . . . ; [the Legislature should] turn toward the state's monitoring system for managed care plan[s], as the object of its efforts to ensure beneficiary access."[28] This report was followed by an audit of DHCS's oversight of its contracted managed care plans, which found that DHCS "has not consistently monitored health plans to ensure that they meet Medi-Cal beneficiaries' medical needs."[29] Advocates and the state legislature should pay close attention to DHCS's process for meeting the managed care access assessment reporting requirement in California's Medi-Cal 2020 waiver in the context of these findings and recommendations. In addition, advocates should push DHCS to correct its flawed reporting on access in the Medi-Cal fee-for-service system.

Access Assessment Timeline

To fulfill the access assessment requirements of the *2020 Demonstration* waiver, the State must amend its contract with its External Quality Review Organization to complete an access assessment.[30] The contract amendment must be completed within 90 days of California's legislature's providing the state with the authority.[31] Once the contract has been amended, DHCS must:

- Submit to CMS no later than 180 days after approval of the contract amendment the access assessment design;

- Establish an Advisory Committee within 60 days of approval by CMS of the contract amendment to provide input into the assessment structure, including network adequacy requirements and metrics, and feedback on an initial draft access assessment report and recommendations that will be published on the DHCS website. The Advisory Committee should include one or more representative(s) from consumer advocacy organizations, providers/provider associations, health plans/health plan associations, and legislative staff;
- Post the initial draft report for a 30-day public comment period after it has incorporated the feedback from the Advisory Committee;
- At the same time it posts the initial draft of the report, make publicly available the feedback from the Advisory Committee; and
- Submit the final access assessment report to CMS no later than 90 days after the initial draft report is posted for public comment.[32]

Access Assessment Report

The report itself must include a comparison of health plan network adequacy compliance across different lines of business, and make recommendations in response to any systemic network adequacy issues, if identified.[33] The initial draft and final report will describe the State's current compliance with the access and network adequacy standards set forth in the Medicaid Managed Care proposed rule or the final rule if it is published prior to submission of the assessment design.[34] In addition to other specific requirements, the assessment will:

- Measure health plan compliance with network adequacy requirements
- Review encounter data including a review of data from sub-capitated plans.
- Measure health plan compliance with timely access requirements using a sample of provider-level data on the soonest appointment availability.
- Review compliance with network adequacy requirements for MCPs, and other lines of business for primary and core specialty care areas and facility access across the entire health plan network.[35]

Conclusion

In the past, the State did not conduct an adequate assessment of access in the fee-for-service program after reducing provider reimbursement rates in 2011. It has also not delivered on its duty to monitor access subsequent to these cuts, thus failing to provide the public with this important information and forcing members of the public to develop other ways to o assess any negative impact the cuts may have had on Medi-Cal beneficiaries' ability to access needed services. Since the managed care access assessment required as part of the *2020 Demonstration* is a one-time assessment, there is all the more reason to ensure that the process of stakeholder engagement and the manner in which the assessment is carried out is inclusive, comprehensive and meaningful, and it is crucial the state maximize this opportunity to address long-held concerns around beneficiary access in managed care.

ENDNOTES

[1] Letter from Andrew Slavin, Acting Administrator, Ctrs. Medicare & Medicaid Servs., to Mari Cantwell, Chief Dpty. Director, Cal. Dept. Health Care Servs. (Dec. 30, 2015), [hereinafter Approval Letter], http://www.dhcs.ca.gov/provgovpart/Documents/Letter_to_State-CA.PDF. For more on 1115 Medicaid Demonstration Waivers, *see* LEO CUELLO, NAT'L HEALTH LAW PROG., HEALTH ADVOCATE: SECTION 1115 WAIVERS: MORE THAN MEETS THE EYE (2012), http://www.healthlaw.org/publications/search-publications/health-advocate-section-1115-waivers-more-than-meets-the-eye.

[2] *See* Approval Letter; *see also* KIM LEWIS, NAT'L HEALTH LAW PROG. LESSONS LEARNED FROM CALIFORNIA: MEDI-CAL'S 1115 WAIVER APPROVED UNTIL 2020 1 (2016), http://www.healthlaw.org/publications/search-publications/CA-Lessons-Jan-2016.

[3] LEWIS, *supra* note 2, at 1.

[4] Letter from Cindy Mann, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. 1 (Aug. 29, 2013), http://www.dhcs.ca.gov/provgovpart/Documents/MMCRuralCountyAppLtrSTCs.pdf.

[5] *Id.* at 5.

[6] CTRS. MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS, CALIFORNIA MEDI-CAL 2020 DEMONSTRATION ¶ 65 (2015) [hereinafter2020 DEMONSTRATION STCs], http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf. DHCS' EQRO contract is with Health Services Advisory Group. CAL. DEPT. HEALTH CARE SERVS., QUALITY MEASURES & REPORTING, http://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.aspx (last visited Apr. 21, 2016).

[7] *See* CAL. DEPT. HEALTH CARE SERVS., STAKEHOLDER INPUT LETTERS, http://www.dhcs.ca.gov/provgovpart/Pages/Stakeholder-Input-Letters.aspx (last visited Apr. 21, 2016); Judi Hillman, *DHCS & CMS Agree to Medi-Cal 2020 Waiver Framework!,* HEALTH ACCESS BLOG (Nov. 4, 2015, 12:24 AM), http://blog.health-access.org/dhcs-cms-agree-to-medi-cal-2020-waiver-framework.

[8] *See* CAL. LEGISLATIVE ANALYST'S OFFICE, 2014-15 BUDGET: ANALYSIS OF HEALTH BUDGET 27-30 (Feb. 20, 2014), http://www.lao.ca.gov/reports/2014/budget/health/health-022014.pdf.

[9] CAL. DEPT. HEALTH CARE SERVS., IMPLEMENTATION OF AB 97 REDUCTIONS (2013), http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf (implementation of these cuts was delayed until June 2013 due to federal injunction).

[10] *See* CAL. WELF. & INST. CODE §14105.19(b).

[11] CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID STATE PLAN AMENDMENTS, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html (last visited Apr. 19, 2016).

[12] *See* Letter from Donald M. Berwick, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (Nov. 18, 2010) (on file with NHeLP's Los Angeles Office) (discussing State Plan Amendments 08-009A; 08-009B2; 08-019).

[13] *Id.* at 1.

[14] *See* Ctrs. Medicare & Medicaid Servs., *Notice of Hearing: Reconsideration of Disapproval of California State Plan Amendments (SPAs) 08-009A; 08-009B1; 08-009B2; 08-009D; and 08-019*, 75 Fed. Reg. 80,058 (2010), https://www.federalregister.gov/articles/2010/12/21/2010-32007/notice-of-hearing-reconsideration-of-disapproval-of-california-state-plan-amendments-spas-08-009a.

[15] *See* Letter from Donald M. Berwick, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (Oct. 27, 2011) [hereinafter 2011 Berwick Letter], https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-08-009B1.pdf (approving SPAs 08-009A, 08-009B1, and 08-009D, and noting that California declined to pursue SPA 08-009B-2 and SPA 08-019).

[16] *See* CAL. WELF. & INST. CODE § 14105.192 (the Governor originally continued the cut on a temporary basis in 2010, and then made it permanent in 2011); *see also* 2011 Berwick Letter at 2.

[17] Letter from Gloria Nagle, Ctrs. Medicare & Medicaid Servs., to Toby Douglas, Cal. Dep't Health Care Servs. (Oct. 27, 2011), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-11-009.pdf (approving SPA 11-009).

[18] 2011 Berwick Letter at 2; *see also* Letter from Gloria Nagle,*supra* 17 at 1.

[19] 2011 Berwick Letter at 2; *see also* CAL. DEP'T OF HEALTH CARE SERVS., MONITORING ACCESS TO MEDI-CAL COVERED HEALTHCARE SERV. (2011), http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf.

[20] CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 19 at 64-65.
[21] CAL. LEGISLATIVE ANALYST'S OFFICE , *supra* note 8 at 27-30.
[22] CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 19 at 63.
[23] LEGISLATIVE ANALYST'S OFFICE *supra* note 8 at 28, 36.
[24] *Id.* at 28-30.
[25] *See* CAL. WELF. & INST. CODE § 14105.192.
[26] *See id.*
[27] LEGISLATIVE ANALYST'S OFFICE, *supra* note 8 at 35.
[28] *Id.* at 38.
[29] ELAINE M. HOWLE, CAL. STATE AUDITOR, IMPROVED MONITORING OF MEDI-CAL MANAGED CARE HEALTH PLANS IS NECESSARY TO BETTER ENSURE ACCESS TO CARE 4 (2015), https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf.
[30] 2020 DEMONSTRATION STCS at ¶ 65.
[31] *See* S.B. 814, 2015-16 Legislative Session (Cal. 2016) (pending bill that would grant DHCS this authority).
[32] 2020 DEMONSTRATION STCS ¶¶ 65-69.
[33] *Id.* ¶ 66.
[34] *Id.; see* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules, 80 Fed. Reg. 104, 31,098 (June 1, 2015) (proposing revisions to 42 C.F.R pt. 438).
[35] 2020 DEMONSTRATION STCS at ¶ 66.