



CALIFORNIA STATE AUDITOR

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FACT SHEET

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The California State Auditor released the following report today:

Medi-Cal Managed Care Program

The Departments of Managed Health Care and Health Care Services Could Improve Their Oversight of Local Initiatives Participating in the Medi-Cal Two-Plan Model

BACKGROUND

The California Medi-Cal Assistance Program (Medi-Cal), which provides public health insurance to certain low-income individuals and families, uses managed care health plans similar to those available to the general public. Nearly 6.7 million Medi-Cal beneficiaries receive their health care through one of three models of managed care—including the two-plan model and, to a lesser extent, on a fee-for-service basis. Under this model, the Department of Health Care Services (Health Care Services) contracts with both a commercial health plan and a local initiative—a locally organized and county-created health plan—to provide services. While Health Care Services oversees compliance with Medi-Cal requirements, the Department of Managed Health Care (Managed Health Care) monitors the financial viability of all managed health care plans.

KEY FINDINGS

During our review of the oversight of the Medi-Cal managed care two-plan model, we noted the following:

- Financial reviews have not been performed promptly, adequately, or consistently and some of the analysis Health Care Services performs overlap the financial viability analysis that Managed Health Care conducts.
 - ✓ Managed Health Care has been chronically late in completing reviews of health plans' financial reports. It took between 33 and 987 days to complete its review of 15 of the 16 financial reports we tested. Further, the reviews did not detect that two of the four local initiatives we visited had repeatedly miscategorized certain expenses.
 - ✓ Although Health Care Services requires plans to demonstrate fiscal soundness, it is inconsistent in performing financial reviews—we found no evidence that staff conduct monthly reviews nor that quarterly reviews include year-to-date totals as stipulated in its internal policies. Additionally, we found many instances in which it did not ensure that all financial requirements are included in order to determine fiscal soundness.
- Both Managed Health Care and Health Care Services fail to conduct medical audits—intended to review several aspects of the provision of health care—of the health delivery system of each local initiative within the frequency required by law.
- Although the Knox-Keene Health Care Services Plan Act of 1975 has established a minimum balance for tangible net equity—the main measure of a managed care health plan's financial viability that the plans must maintain—it did not establish an upper limit. We found that the local initiatives' actual balances ranged from 176 percent to 1,180 percent of the required minimum.
- The four local initiatives we visited generally had adequate fiscal processes and controls to monitor their administrative expenses and, although all use similar methods to set and approve salaries, salaries and retirement benefits of their top executives vary significantly—CEO compensation ranged from roughly \$230,000 to nearly \$804,000 in 2010.

KEY RECOMMENDATIONS

We make numerous recommendations to both departments that they develop formal policies to ensure that their financial reviews are timely and that Managed Health Care ensure expenses are categorized correctly. Further, we recommend that Health Care Services review all four financial soundness elements and that it conduct reviews consistently. Moreover, we recommend that both departments either perform or ensure that annual medical audits are conducted timely.

