

The California State Auditor released the following report today:

## California Department of Health Care Services

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

### BACKGROUND

Administered by the California Department of Health Care Services (Health Care Services), the California Medical Assistance Program (Medi-Cal) is the State's implementation of the federal Medicaid program that provides health care services to approximately 12 million aged, disabled, and low-income Californians (beneficiaries) through two different delivery systems—fee-for-service and managed care. Under the fee-for-service system, beneficiaries can receive medical services from any health care provider who participates in Medi-Cal—the provider is reimbursed for the services delivered. Under managed care, the beneficiary receives medical services through a single provider selected from within the proper Medi-Cal Managed Care Health Plan's (health plans) network of primary care physicians. Both Health Care Services and the California Department of Managed Health Care (Managed Health Care) assess each health plan's ability to serve enrollees.

### KEY FINDINGS

During our audit of Health Care Services' oversight of health plans, we noted:

- Health Care Services did not verify health plan data: therefore, it cannot ensure that health plans had adequate provider networks to serve Medi-Cal beneficiaries.
- 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, which uses the data to perform quarterly assessments of network adequacy.
- Health Care Services' process for reviewing provider directories is flawed: the tool it uses to evaluate the accuracy of the directories is inadequate and methods for determining which providers to contact for verification are inconsistent. We found inaccuracies in the provider directories for three health plans in selected counties, yet Health Care Services had not identified any inaccuracies in its evaluations of those same directories.
- Health Care Services' Medi-Cal Managed Care Office of the Ombudsman (ombudsman office), which investigates and resolves complaints by or on behalf of beneficiaries about the health plans, has a telephone system that cannot handle the volume of calls it receives nor can its staff answer all of the calls the system does accept.
- Health Care Services has not consistently monitored health plans to ensure that they meet beneficiaries' medical needs—it did not perform any annual medical audits before 2012 and performed medical audits on less than half of the health plans in fiscal year 2013–14.
- Health Care Services did not ensure that Managed Health Care performed the quarterly assessments of provider networks for existing health plans as per their agreement. In fact, Managed Health Care has not performed assessments for health plans that serve 28 counties since the first quarter of 2014.
- Although permitted by law, neither Managed Health Care nor Health Care Services relies on the work performed by the other to meet their overlapping responsibilities—Managed Health Care could rely on Health Care Services' review since Health Care Services is required to review the 22 Medi-Cal health plans more frequently.

### KEY RECOMMENDATIONS

We made several recommendations to Health Care Services including the following:

- Establish a process to verify the accuracy of provider network data the health plan uses to demonstrate that it meets network adequacy standards.
- Review each health plan's process for ensuring the accuracy of directories, identify best practices, and require health plans to follow those practices. It should also revise its provider directory review process to identify inaccuracies.
- Upgrade or replace the ombudsman office's telephone system to handle the volume of calls it receives.
- Increase its oversight of Managed Health Care and ensure it conducts quarterly reviews of health plans.

Also, Managed Health Care should determine if it can rely on Health Care Services' annual audits to eliminate any duplicative work in reviewing health plans.