Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

OVERSIGHT HEARING
"Achieving and Maintaining Adequate Provider Networks in Medi-Cal Managed Care"
Thursday, November 9, 2017
10 a.m.
State Capitol - Room 4203

Consultant: Scott Ogus

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II. PRESENTATION: MEDI-CAL MANAGED CARE RATE-SETTING AND IMPLEMENTATION OF NEW STATE AND FEDERAL REQUIREMENTS
Mari Cantwell, Chief Deputy Director, Department of Health Care Services

III. PANEL: MEDI-CAL MANAGED CARE ORGANIZATIONS
Steve Melody, President - Medicaid Health Plan for CA, Anthem Blue Cross/WellPoint
Dr. Brad Gilbert, Chief Executive Officer, Inland Empire Health Plan
Alan McKay, Chief Executive Officer, Central CA Alliance for Health

IV. REACTOR PANEL: MEDI-CAL PROVIDERS AND CONSUMERS
Michelle Baca, Associate Director – Govt. Relations, California Medical Association
Jeff Conklin, Vice President - Payer & Network Strategies, Adventist Health
Meaghan McCamman, Assistant Director of Policy, California Health+ Advocates
Robert Stone, CEO, & Joseph Alvarnas, Dir. of Value Based Analytics, City of Hope
Linda Nguy, Policy Advocate, Western Center on Law and Poverty
Kiran Savage-Sangwan, Health Integration Policy Dir., CA Pan-Ethnic Health Network

V. PUBLIC COMMENT

VI. DISCUSSION AND CLOSING REMARKS

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

Speaker Biographies

PRESENTATION: MEDI-CAL MANAGED CARE RATE-SETTING AND IMPLEMENTATION OF NEW STATE AND FEDERAL REQUIREMENTS

Mari Cantwell, Chief Deputy Director, Department of Health Care Services
On February 25, 2013, Governor Brown appointed Mari Cantwell as Chief Deputy Director of Health Care Programs for the California Department of Health Care Services (DHCS). Home to the state's Medicaid program, called Medi-Cal, DHCS administers programs to support the vital health care needs of more than 13.3 million Californians. DHCS employs more than 3,700 staff and manages total expenditures of more than $95 billion.

Mari also assumed the role of State Medicaid Director in February 2015. She is responsible for the overall management of Health Care Delivery Systems, Health Care Financing, and Health Care Benefits and Eligibility. These responsibilities allow DHCS to fulfill its primary mission of providing health benefits to Californians.

Prior to her appointment, Mari served as the Deputy Director of DHCS Health Care Financing, where she was responsible for the development, promotion, and implementation of health care delivery systems for Medi-Cal beneficiaries. Before joining DHCS, from 2005 to 2011, Mari worked as the Vice President of Finance Policy for the California Association of Public Hospitals and Health Systems.

Mari received her Master's degree in public policy from the University of California at Los Angeles, Luskin School of Public Affairs, and her Bachelor of Arts degree in public policy and American institutions from Brown University.

PANEL: MEDI-CAL MANAGED CARE ORGANIZATIONS

Steve Melody, President - Medicaid Health Plan for CA, Anthem Blue Cross/WellPoint
Steve Melody is President of California Medicaid for Anthem Blue Cross. In this role, he is responsible for the management and strategic direction of Anthem's California Medicaid programs which provide health care access and services to nearly 1.3 million members. He oversees membership, state relations, cost of care, clinical management, product development, network strategy, operations and overall profit and loss. In addition, Steve identifies, develops, oversees, and implements key initiatives that support the organization's strategic goals, including quality improvement.

Joining Anthem Blue Cross in 1997, he held numerous leadership positions and was Regional Vice President of California Medicaid before being named to his current role. Steve's previous positions include Director of Network Development and Management; Regional Vice President/Chief of Staff, Planning, Strategy and Innovation and Vice President of Health Care Management.

With nearly 30 years experience in the health care and managed care environments, he has managed and directed departmental operations and functions of Provider Contracting, Provider Services, Provider Education, Network and Regulatory Compliance throughout Northern and Southern California.

Steve received his Bachelor of Science degree in Business Administration with a concentration in Marketing from California State University, Sacramento, CA and completed the Executive Education Program at the Mendoza College of Business, University of Notre Dame. He resides in Elk Grove with his wife and they have 4 children (and 3 dogs!).

Dr. Brad Gilbert, Chief Executive Officer, Inland Empire Health Plan
Dr. Bradley Gilbert was appointed chief executive officer of Inland Empire Health Plan (IEHP) in October 2008. Since the organization's inception, he has played a pivotal role in guiding IEHP to its place as a nationally-recognized leader in public healthcare. As one of the largest public not-for-profit health plans in California, with over 1.2 million members, Dr. Gilbert is leading IEHP into the healthcare reform era.

Dr. Gilbert launched his career at IEHP in 1996 as chief medical officer, developing a Medical Services Department and helping IEHP qualify for a Knox-Keene state licensure. Later, he served as executive officer, responsible for medical management, operations and contracting/network management, marketing, human resources, and compliance.

Dr. Gilbert is also a healthcare industry leader at the state level. In 2010, he was appointed as a board member of the California Association of Health Plans (CAHP), an organization representing 39 California plans. In 2011, he was appointed chair of the CAHP State Programs Committee. Dr. Gilbert is a member of the Board for the Local Health Plans of California (LHPC), and was a member of the Medi-Cal 1115 Waiver Stakeholder Committee – a committee that helped shape the 1115 Demonstration Waiver in California, which funds hospitals and care for the low-income. He is a board member of the California Association of Public Hospitals (Safety Net Institute). Additionally, Dr. Gilbert is the chair of the Inland Empire EHR Resource Center, which is part of the Inland Empire Health Information Exchange. In July 2014, Dr. Gilbert was selected to serve on the California HealthCare Foundation (CHCF) board of directors.

His strong track record in the public health industry began as the Director of Public Health/Health Officer for Riverside County; where he gained insight into the healthcare challenges that Inland Empire residents face. He was responsible for 11 primary care clinics, assigned to special projects in managed care – including participation in development of an IPA and medical liaison to manage care contractors. He supervised communicable disease control, certain environmental health monitoring and public health protection for the county.

Dr. Gilbert attended the University of California, Berkeley, where he earned his bachelor's degree in physiology/anatomy. He received a medical degree from the University of California, San Diego and a master's degree in public policy from the University of California, Berkeley. He is Board Certified in General Preventive Medicine.

Alan McKay, Chief Executive Officer, Central CA Alliance for Health
Alan McKay has served as the Chief Executive Officer (CEO) of the Central CA Alliance for Health since the health plan's inception in Santa Cruz County in April 1995. He previously worked in Bay Area managed care for 12 years, as a Manager in Ernst & Young's San Francisco health care consulting practice from 1984 to 1987, and as Director of Managed Care at El Camino Hospital from 1987 to 1993.

Alan holds a Master of Public Health degree from University of California at Berkeley, and a Bachelor of Arts degree in Psychology from the University of California at Santa Cruz. He is a Member of the board of Local Health Plans of California (LHPC), the professional association of sixteen public, non-profit Medi-Cal health plans in California. He is a Member of the Merced County Health Care Consortium, the Monterey Regional Health Development Group, Inc. (MoreHealth), and the Health Improvement Partnership of Santa Cruz County.

REACTOR PANEL: MEDI-CAL PROVIDERS AND CONSUMERS

Michelle Baca, Associate Director – Govt. Relations, California Medical Association
Michelle Baca is an Associate Director in the Center for Government Relations at the California Medical Association. Her primary advocacy involves Medi-Cal and physician workforce issues. Prior to joining CMA, she gained nearly a decade of experience in state government, working on health and human services issues for the California Department of Finance and the California Legislature.

Jeff Conklin, Vice President - Payer & Network Strategies, Adventist Health
Mr. Conklin serves as corporate vice president, Payer & Network Strategies for Adventist Health, and president Adventist Health Managed Care. He is also president/CEO of Adventist Health Plan, Inc., a restricted license Knox-Keene plan launched in 2016 serving Medi-Cal members in Kings County, CA. A health care executive with extensive experience in senior leadership roles for health care systems, hospitals, IPAs/Medical Groups and management services organizations, Conklin possesses expertise in managed care strategy and contracting, population health, medical group management, and developing/managing physician organizations.

Meaghan McCamman, Assistant Director of Policy, California Health+ Advocates
Meaghan has nearly a decade of experience representing safety-net providers in California and across the country. She is currently Assistant Director of Policy for the California Primary Care Association (CPCA) where she is responsible for policy and advocacy on behalf of community clinics in the areas of managed care, behavioral health and health integration, 1115 Waiver, the Health Benefit Exchange, rural health, veterans issues, Medicare, and the 330 grant program. Meaghan previously led CPCA's efforts around state implementation of the Affordable Care Act, including representing community clinic interests in the development of Covered California and Medicaid expansion. She also previously served as Director of Programs for the National Rural Health Association in Washington, DC. Meaghan holds an MPA from George Mason University.

Robert W. Stone, Chief Executive Officer, City of Hope

Robert W. Stone is President and Chief Executive Officer of City of Hope, a cancer research and treatment institution dedicated to innovation in biomedical research and the delivery of compassionate, world-class patient care. Stone sets the strategic vision for City of Hope, driving business development and maximizing potential growth. He leads a diverse team of talented high-level individuals committed to humanitarian service and to ensuring access to the institution's breakthrough discoveries and specialized therapies.

In his career at City of Hope, Stone has served in a number of increasingly responsible roles. He joined City of Hope in 1996 as associate general counsel and was promoted to general counsel for the medical center in 2000. In 2003, he was named City of Hope's general counsel and corporate secretary. He became City of Hope's chief strategy and administrative officer in 2009, leading the creation and development of the organization's 10-year strategic plan.

Stone also served as president and executive officer of the City of Hope Medical Foundation, an entity launched in June 2011 to increase collaboration between physicians and staff and to enable more coordinated care for patients. In this role, Stone worked with the foundation board to plan, design and implement the foundation strategy. He was also responsible for the day-to-day management of the foundation, including overseeing the foundation-operated clinics, the management services staff of the foundation and managed-care contracting for City of Hope.

As president of City of Hope, a role he assumed in August 2012, Stone was responsible for executing the strategy for the larger institution, guiding business development and overseeing all operational, financial, human capital and strategic functions. He assumed the dual role of chief executive officer in January 2014.

Prior to City of Hope, Stone was a practicing attorney at the firms of Christa & Jackson and Hanna and Morton. He earned his law degree at the University of Chicago Law School.

Joseph Alvarnas, M.D., Director of Value Based Analytics, City of Hope

Joseph Alvarnas, M.D., is City of Hope's Director of Value Based Analytics; Associate Clinical Professor, Department of Hematology & Hematopoietic Cell Transplantation; Clinical Quality Director, Alpha Clinic; Interim Medical Director of Community Practices and a hematologist/oncologist. His areas of expertise are bone marrow and stem cell transplantation.

At City of Hope since 2008, Dr. Alvarnas earned his medical degree at University of California, San Francisco, and did fellowships in hematology and bone marrow transplantation at Stanford University Medical Center. An articulate spokesman on topics ranging from hematology to health policy, Dr. Alvarnas is also editor-in-chief of the publication, Evidence-Based Oncology. He speaks Spanish, Portugese and Italian in addition to English.

Linda Nguy, Policy Advocate, Western Center on Law and Poverty

Linda Nguy is Policy Advocate for the Western Center on Law and Poverty, specializing in health care issues that affect poor Californians. Prior to joining Western Center, Linda worked with the State of Washington and Mississippi to help establish their state-based health exchange. Specifically, she drafted the online application for subsidized and unsubsidized qualified health plans. She also worked on California's behavioral health adjudication system and as Policy Associate for the Latino Coalition for a

Healthy California. Linda received her MPP/MBA from the University of Minnesota, Twin Cities and undergraduate degree from Brown University.

Kiran Savage-Sangwan, Health Integration Policy Dir., CA Pan-Ethnic Health Network
Kiran Savage-Sangwan is the Health Integration Policy Director at the California Pan-Ethnic Health Network (CPEHN), a statewide multicultural health policy organization. In her position, she leads policy and community engagement efforts to improve access to and quality of health, mental health, and oral health care. Prior to joining CPEHN, she worked as the Director of Legislation and Advocacy for the National Alliance on Mental Illness (NAMI) California. Kiran has also worked at the American Civil Liberties Union (ACLU) of Northern California and the New York Civil Liberties Union, primarily focused on immigrants' rights.

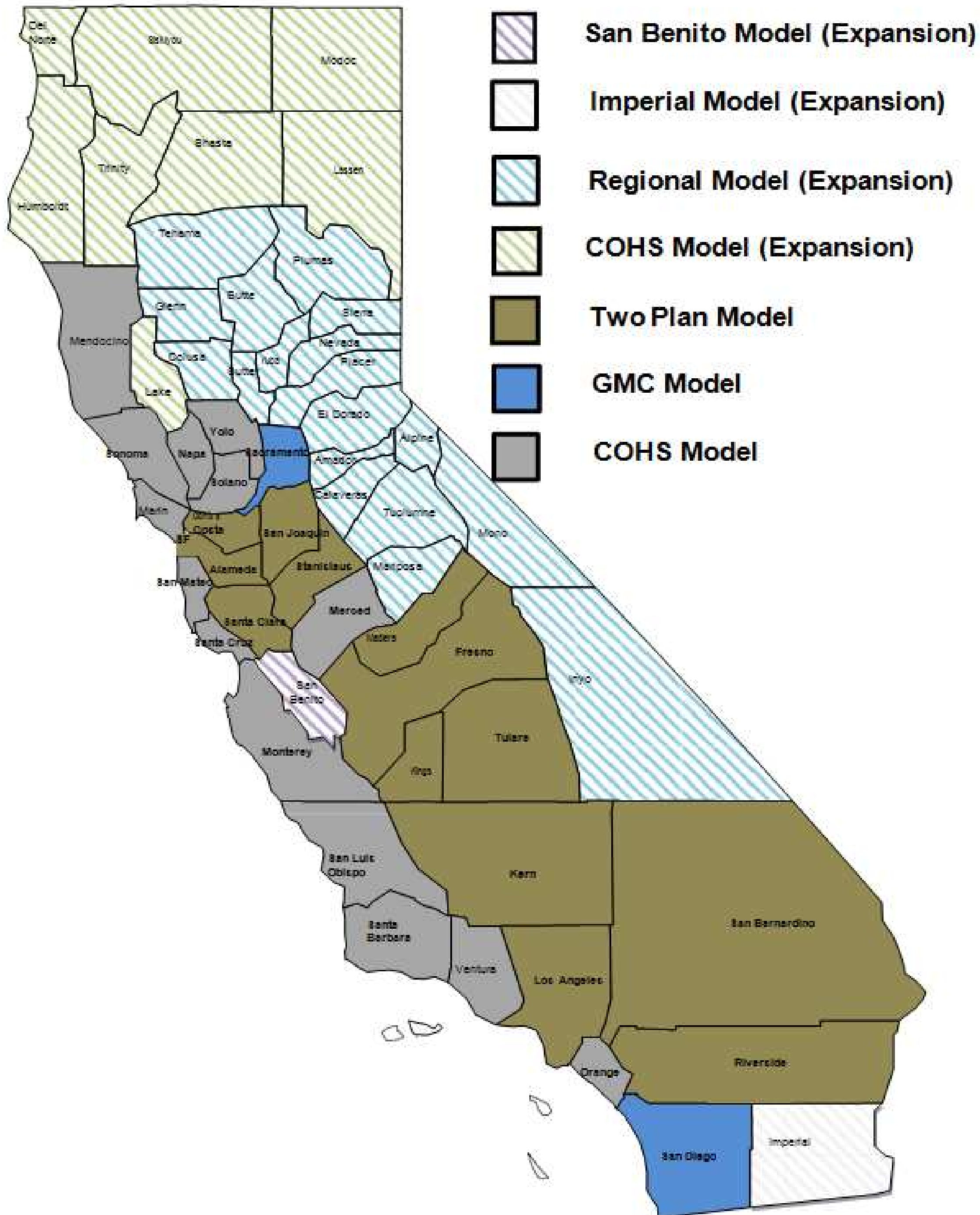
MEDI-CAL MANAGED CARE AND NETWORK ADEQUACY – BACKGROUND

Thirty-Five Years of Medi-Cal Managed Care. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). In addition to regulatory oversight of the commercial managed care market, the Knox-Keene Act authorized the state to license health maintenance organizations and pre-paid health plans to enroll Medi-Cal beneficiaries. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, there are four primary models of managed care delivery in the Medi-Cal program:

- *County Organized Health Systems* – In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered managed care plans. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties described below (see *Expansion to Rural Counties*, below). Beneficiaries in these counties receive services through Partnership Health Plan of California.
- *Geographic Managed Care* – In 1992, the department designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.
- *Two Plan Model* – In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other smaller managed care plans to provide services to Medi-Cal beneficiaries.
- *Regional Model* – AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of Medi-Cal managed care into the twenty-eight rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. 8 counties transitioned into the COHS model, while twenty counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra,

Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties (except San Benito and Imperial) receive services through either Anthem Blue Cross, or California Health and Wellness. Beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal, while beneficiaries in Imperial County receive services through either California Health and Wellness or Molina Health Systems.

MEDI-CAL MANAGED CARE MODELS



Source: Department of Health Care Services, Medi-Cal Managed Care Division

Most Major Beneficiary Populations Transitioned to Medi-Cal Managed Care.
In 2000, approximately half of Medi-Cal beneficiaries received services in the Medi-Cal managed care delivery system. Over the subsequent fifteen years, several populations previously exempt, enrolled in other managed care coverage, or uninsured were mandatorily enrolled in Medi-Cal managed care. As of the 2017 Budget Act, 79.64 percent of Medi-Cal beneficiaries, or 10.9 million Californians, will receive services through Medi-Cal managed care in 2017-18.

Seniors and Persons with Disabilities
The state's 2010 Section 1115 "Bridge to Reform" waiver included a proposal to provide a more organized and coordinated care delivery system for seniors and persons with disabilities (SPDs). SPDs are non-dual-eligible Medi-Cal beneficiaries who are 65 and over or who have a disability. Prior to the waiver, SPDs were only required to be enrolled in managed care for their non-long term care Medi-Cal benefits in COHS counties. The terms of the Waiver included mandatory enrollment of SPDs into managed care for non-long term care Medi-Cal benefits in all counties operating managed care models. Effective June 1, 2011, SPDs were mandatorily enrolled in managed care in two plan model and geographic managed care counties. The transition was phased-in over a 12 month period, with beneficiaries enrolled by birth month.

Healthy Families Program Transition from MRMIB
Title XXI of the Social Security Act permits states to provide health care services to children up to 250 percent of the federal poverty level, known as the Children's Health Insurance Program (CHIP). The provisions of CHIP allowed states to integrate these children into an existing state Medicaid program, or to create a stand-alone program. California, choosing the latter option, established the Healthy Families Program, which provided health, dental and vision coverage to eligible children and was administered by the Managed Risk Medical Insurance Board (MRMIB). The 2012 Budget Act, as part of a package of budget-balancing solutions, eliminated the Healthy Families Program, transferring its beneficiaries to Medi-Cal over a 12 month period. The transition began on January 1, 2013 and proceeded in four phases. The new program for these beneficiaries is known as the Optional Targeted Low-Income Children Program (OTLICP) and, as of the 2017 Budget Act, covers 865,760 children in managed care and 65,140 in fee-for-service.

Expansion to Rural Counties
AB 1467, as part of a package of budget-balancing solutions in the 2012 Budget Act, authorized the expansion of managed care to twenty-eight rural counties in which it had previously not been operative. The expansion began on November 1, 2013, with some phase-in provisions for SPDs in those counties. Eight counties transitioned into a COHS model of managed care: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Partnership Health Plan of California serves as the COHS plan for these eight counties. The remaining twenty counties transitioned into a new Regional Model, in which the department contracts with two commercial plans (except in San Benito and Imperial) to cover beneficiaries. The twenty rural expansion counties are: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolomne, Yuba, Imperial, and San Benito.

Coordinated Care Initiative
The 2012 Budget Act included a demonstration project to better integrate the health care delivery system for individuals dually eligible for Medicare and Medi-Cal ("dual-eligibles"). SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, and later SB 94

(Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, implemented the proposal, known as the Coordinated Care Initiative. This new program passively enrolled dual-eligibles into an integrated managed care plan for both Medicare and Medi-Cal benefits, known as Cal MediConnect, in seven pilot counties. All other Medi-Cal beneficiaries in those counties, including those that opted out of Cal MediConnect, were mandatorily enrolled in managed care for their Medi-Cal benefits, including long-term services and supports like In-Home Supportive Services (IHSS) and skilled nursing facilities, which had previously been offered in the fee-for-service delivery system. Passive enrollment began in March 2014 and was completed in all seven counties in August 2016. The CCI Counties are: San Mateo, San Bernardino, Riverside, Los Angeles, Orange, San Diego, and Santa Clara.

Upon release of the 2017 Governor's Budget, the Director of Finance certified that CCI would no longer be cost-effective. Under the provisions of Section 34 of SB 94 the program will be discontinued effective January 1, 2018. However, the 2017 Budget Act continues the Cal MediConnect program and mandatory enrollment of dual-eligibles in managed care for Medi-Cal benefits including long-term services and supports (except IHSS).

Optional Expansion of Medi-Cal (Affordable Care Act)
The federal Affordable Care Act authorized states to expand their Medicaid programs to previously uninsured individuals. ABX1 1 (John A. Perez) and SBX1 1 (Hernandez), Chapters 3 and 4, Statutes of 2013, authorized California's Optional Expansion of the Medi-Cal program. The Optional Expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Optional Expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits. The 2017 Budget Act assumes Optional Expansion enrollment of 3.9 million beneficiaries in 2017-18.

Major Managed Care Exceptions ("Carve-Outs")

1) California Children's Services (CCS) – The CCS program provides specialized health care services to children up to twenty-one years of age with certain serious diseases or health conditions. Services provided in this program are generally exempt from inclusion in managed care and are provided in the fee-for-service delivery system. However, SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorizes the department to implement a Whole Child Model, which would incorporate CCS benefits into managed care in twenty-one counties. Implementation is scheduled to begin no sooner than July 2017.
2) Long-Term Care/Home and Community Based Services – Long-term care services, such as those provided by a skilled nursing facility or intermediate care facility for the developmentally disabled, are exempt from inclusion as a managed care benefit and are reimbursed in the fee-for-service delivery system, except in Coordinated Care Initiative counties. Other home and community based services, such as In-Home Supportive Services (IHSS) are also fee-for-service benefits.
3) Dental Services (except Dental Managed Care counties) – In all counties, except Sacramento and Los Angeles, dental benefits in Medi-Cal (Denti-Cal) is provided on a fee-for-service basis. The benefits are provided to beneficiaries by the department's dental fiscal intermediary, Delta Dental, which maintains provider networks and administers benefits in an at-risk arrangement that is similar to, but distinct from, a managed care plan's operations.

Federal Medicaid Regulations Require Actuarially Sound Capitation Rates. Section 1396b(m)(2)(A)(iii) of Title 42 of the United States Code requires that no federal matching funds be

paid to a state for capitation payments to a managed care plan unless, among other requirements, the "prepaid payments to the [plan] are made on an actuarially sound basis". Section 438.6(c)(1)(i) of Title 42 of the Code of Federal Regulations defines actuarially sound capitation rates as rates that:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified, as meeting these requirements, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

In addition, Section 1396a(a)(30)(A) of Title 42 of the United States Code requires state Medicaid programs to provide payment for available care and services "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".

DHCS' Capitated Rate Development Division (CRDD) develops capitation rates in consultation with the department's contracted actuary, Mercer. Once rates have been developed, Mercer provides the actuarial soundness certification required by federal regulations. Historically, the rate development process resulted in a rate range, which represented the minimum and the maximum actuarially sound capitation payment that could be supported by encounter and claims data. The department typically pays the minimum rate in the range, which allows for other governmental entities to provide additional nonfederal dollars up to the maximum of the rate range to draw down additional federal matching funds. New federal regulations finalized in May 2016 require certification of a single rate, which will require the department to move to a prospective rate-setting process.

Knox-Keene Act and Network Adequacy. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to requirements related to financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans, including Medi-Cal managed care plans (except COHS), designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability:

1) *Urgent care without prior authorization*: **within 48 hours**.
2) *Urgent care with prior authorization*: **within 96 hours**.
3) *Non-urgent primary care appointments*: **within 10 business days.**
4) *Non-urgent specialist appointments*: **within 15 business days.**
5) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

Plans are also generally required to ensure that:

1) Primary care physicians are **located within 15 miles or 30 minutes** of a beneficiary's place of residence.
2) Plan networks include **one primary care provider for every 2,000 beneficiaries.**

Non-COHS Medi-Cal managed care plans are required to have a Knox-Keene license and are, therefore, required to be in compliance with these provisions. DHCS contracts with COHS plans to provide health care services to Medi-Cal beneficiaries in those counties. Although they are not required to have a Knox-Keene license, the department's sample contract with COHS plans includes the same or greater network adequacy and timely access requirements as the Knox-Keene Act.

Recent Medicaid Managed Care Regulations Expand Network Adequacy Requirements. In May, 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final rulemaking for state Medicaid programs with beneficiaries served by managed care organizations. One of the most significant changes imposed by the regulations is the requirement that capitation rates be set at a single rate, rather than in a range, which will change the way DHCS and Mercer calculate capitation rates for Medi-Cal managed care plans. In addition, the rules require:

- California's network adequacy standards expand from one provider type (primary care) to an additional six provider types.
- Collection of quality data to be used to improve the managed care program.
- Enhanced beneficiary supports.
- Monthly, rather than semi-annual, updates of provider directories
- Implementation of an 85 percent medical loss ratio (MLR) for Medi-Cal managed care plans.

2017 Legislation Specifies Network Adequacy Requirements for Medi-Cal Managed Care. AB 205 (Wood) and SB 171 (Hernandez), Chapters 738 and 768, Statutes of 2017, codified in state law specific requirements for Medi-Cal managed care related to implementation of the federal managed care regulations. In particular, these bills manage the implementation of the 85 percent MLR for Medi-Cal managed care plans, including the remittance process, and establish time and distance and appointment availability standards for the various classes of providers covered by the new federal rules.

Commencing January 1, 2018, the time and distance standards are as follows:

- *Primary care providers*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Hospitals*: **15 miles or 30 minutes** from the beneficiary's place of residence.
- *Dental managed care*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Obstetrics and gynecology*: **10 miles or 30 minutes** from the beneficiary's place of residence.

Commencing July 1, 2018, the time and distance standards are as follows:

- *Specialists*, including cardiology/interventional cardiology, nephrology, dermatology, neurology, endocrinology, ophthalmology, ear, nose, and throat/otolaryngology, OB-GYN specialty care, orthopedic surgery, gastroenterology, physical medicine and rehabilitation, general surgery, psychiatry, hematology, oncology, and pulmonology, HIV/AIDS specialists/infectious diseases, and outpatient mental health services, the following time and distance standards by county:

    1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,
4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Pharmacy services*: 10 miles or 30 minutes from the beneficiary's place of residence (all counties).

- *Outpatient substance use disorder services* other than opioid treatment programs, the following time and distance standards by county:

1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura; and,
3) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

- *Opioid treatment programs*, as follows:

1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Skilled nursing facility and intermediate care facility services*, the following time and distance standards by county:

1) Within **five business days** of the request: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
2) Within **seven business days** of the request: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) Within **fourteen calendar days** of the request: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,
4) Within **fourteen calendar days** of the request: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *County Drug Medi-Cal-Organized Delivery System (DMC-ODS)*: appointment within **three business days** to an opioid treatment program (all counties).

- *Dental managed care plan services*:
  Routine pediatric services: appointment within **four weeks** of a request.
  Specialist pediatric services: appointment within **thirty calendar days** of a request.

Provider Participation May Not Be Keeping Pace With Enrollment. In 2012-13, just prior to the implementation of the Affordable Care Act, 5.1 million Californians were enrolled in Medi-Cal managed care. As of the 2017 Budget Act, 2017-18 enrollment in Medi-Cal managed care was projected to be 10.9 million, an increase of 214 percent over 2012-13. While this significant increase in coverage has provided measurable health benefits to lower-income Californians, it is unclear whether Medi-Cal managed care plan provider networks have been able to keep pace with the sharp rise in enrollment. A June 2017 report from the California Health Care Foundation titled "*Physician Participation in Medi-Cal: Is Supply Meeting Demand?*" surveyed physicians renewing licensure in 2015 to gauge participation in the Medi-Cal program. The report found that, between 2013 and 2015, the percentage of physicians serving Medi-Cal patients decreased from 69 percent to 64 percent, although the overall number of full-time equivalent physicians serving Medi-Cal patients increased by nine percent, likely due to previously uninsured patients seen by these physicians gaining coverage under the Medi-Cal expansion. However, the report also found this modest increase in full-time equivalent physician participation did not keep pace with the growth in enrollment, as the number of full-time equivalent physicians for each 100,000 Medi-Cal beneficiaries declined significantly. For primary care physicians, there were 39 full-time equivalents in 2015 compared to 59 in 2013, a 33.9 percent decline. For non-primary care physicians, there were 63 full-time equivalents in 2015 compared to 91 in 2013, a 30.8 percent decline.

Medi-Cal Managed Care Plans May Have Made Significant Financial Gains From Expansion. A recent article published November 5, 2017, in the Los Angeles Times, titled "*Insurers make billions off Medicaid in California during Obamacare expansion*", used data from unaudited financial disclosures from Medi-Cal managed care plans to estimate that these plans made $5.4 billion in profits from 2014 to 2016, primarily due to higher rates paid for beneficiaries receiving coverage under the expansion of Medi-Cal pursuant to the Affordable Care Act. These findings suggest capitation rates paid to Medi-Cal managed care plans do not align with the actual utilization and provision of health care services to Medi-Cal beneficiaries during this time period.

In the article, the director of DHCS indicates that these data do not account for additional auditing, rate adjustments and retroactive recoupments that will occur in the future. DHCS is required to adjust capitation rates paid since the implementation of the expansion to account for actual encounter and utilization data reported by the plans. Downward adjustments to these capitation rates for prior periods have resulted in significant expected recoupments from Medi-Cal managed care plans. The May 2017 Medi-Cal Local Assistance Estimate indicates the department expects to begin recoupment January 2017 for the expansion population and will recoup $5.3 billion, all federal funds, for the period from July 2015 through December 2016. There may be additional recoupments for periods after December 2016. It is unclear whether the data cited in the Los Angeles Times article reflects these expected recoupments. The subcommittee will continue to analyze and monitor these data to determine what impact, if any, these rates have on whether plans are able to maintain adequate provider networks for Medi-Cal beneficiaries.