



ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY
for STATE HEALTH POLICY

Improving Managed Care Quality and Accountability Using State Regulatory Strategies



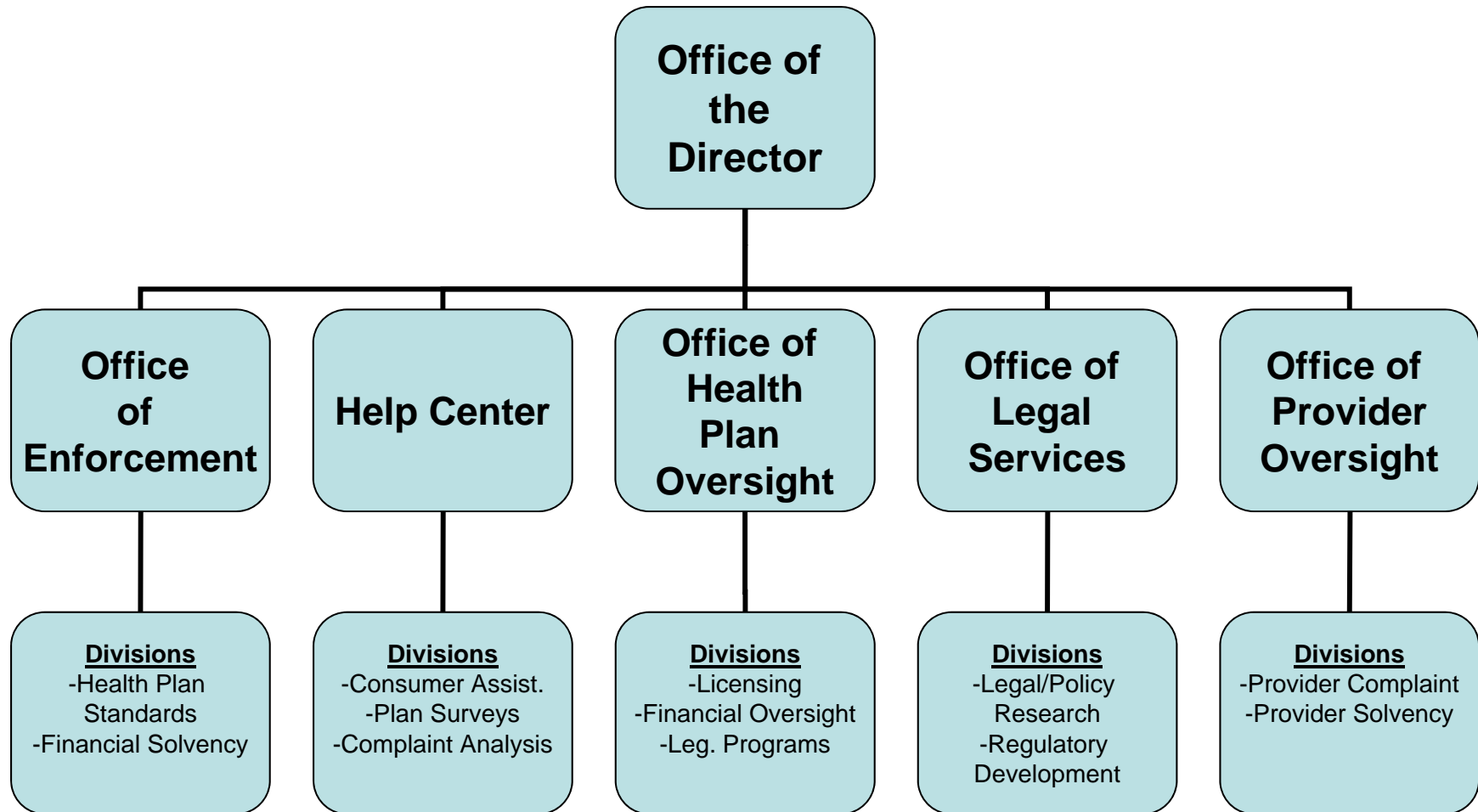
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Office of Enforcement

California Department of Managed Health Care



- ❖ The Department of Managed Health Care (DMHC), is a first-in-the-nation HMO consumer rights organization that helps California consumers resolve problems with their health plan and works to provide a more stable and financially solvent managed care system.
- ❖ Currently, the DMHC licenses and regulates roughly 124 health care service plans operating in the State of California with a total enrollment of more than 55 million members.

Department Structure



OFFICE OF ENFORCEMENT



- ❖ Handles the litigation needs of the Department, represents the Department in actions to enforce the managed health care laws and in actions that are brought against the Department
- ❖ Investigates and prosecutes actions involving health plan compliance with financial and non-financial requirements, the quality, accessibility, and continuity of care, denial of treatment and claims, and reporting and solvency laws
- ❖ Investigates and prosecutes actions generated within the Office itself (undercover investigations) and those referred from other divisions within the Department

Sources of Referrals to the Office of Enforcement

❖ Help Center

- Enrollee grievances, Independent Medical Review (IMR) violations

❖ Medical Surveys Division

- Plan operational violations (administrative capacity, quality of care, provider oversight (peer review), and systemic issues)

❖ Office of Health Plan Oversight

- Plan fiscal solvency and licensing requirements

❖ Office of Provider Oversight

- Claims payment/reimbursement, provider solvency, plan-provider contracts

❖ In-House Enforcement Investigations



- ❖ Assists consumers with health care issues and ensures that managed health care patients receive the medical care and services to which they are entitled
- ❖ Receives, reviews and processes consumer calls requesting general information or assistance
 - 80,387 consumer calls handled in 2008
- ❖ Processes consumer complaints and requests for Independent Medical Review (IMR) of health plan denials
 - 10,094 consumer complaints resolved in 2008
 - 2,067 IMRs processed in 2008

IMR Implementation Referral

- ❖ Help Center referred several consumer complaints concerning a plan's failure to timely implement IMR decisions
- ❖ Concurrently, a non-routine survey of the plan performed by Medical Surveys revealed similar violations
- ❖ Enforcement's investigation confirmed the violations, which, by law, carry a \$5,000 per day penalty
- ❖ Working with the Plan, the DMHC reached a settlement whereby the Plan paid a \$500,000 administrative penalty and donated \$500,000 to California Health Consumer Alliance, a third party organization that used the money to educate consumers about their appeal and IMR rights in California

MEDICAL SURVEYS DIVISION



- ❖ Evaluates and promotes health plan regulatory compliance and quality improvement as related to health care delivery systems
- ❖ Plans and conducts on-site evaluations of all licensed health plans at least once every three years
- ❖ Issues reports to the public that discuss plan performance in the areas of health care accessibility, utilization management, quality improvement, and member grievances/appeals
- ❖ Advises and assists health plans and assists other divisions of the DMHC in evaluating issues related to health care delivery and managed care operations

Quality of Care Referral



- ❖ Referred from the Medical Surveys Division following a whistleblower complaint that over 900 enrollee quality of care complaints were being ignored and not investigated
- ❖ Joint on-site non-routine investigation involving Medical Surveys and Enforcement staff confirmed whistleblower's allegations
- ❖ Plan was assessed a \$1.25 million fine and agreed to a corrective action plan involving unannounced follow-up audits by Medical Surveys and potential additional fines of \$2 million if corrective action was not completed

OFFICE OF HEALTH PLAN OVERSIGHT



- ❖ Works toward assuring that licensed health plans provide the delivery of preventive and medically necessary health care services in an appropriately organized and financially stable managed health care setting
- ❖ Division of Licensing monitors and evaluates the financial viability of health plans to ensure continued access to health care services for California consumers. This is accomplished by reviewing financial statements, analyzing financial arrangements and other information submitted as part of the licensing, material modification, and amendment process

Licensing Provider Contract Referral

- ❖ Health Plan Oversight received notice that a plan intended to cancel its contract with a very large provider group in California
- ❖ The cancellation would have affected roughly 2,600 of the plan's enrollees due to a proposed block transfer to another provider group
- ❖ Enforcement's investigation revealed that the proposed provider group lacked the ability to accommodate the influx of enrollees
- ❖ The DMHC intervened to effectuate an agreement whereby the plan negotiated a mutually acceptable contract with the provider group that was subject to the cancellation, which ensured the continuity of care for all of the enrollees involved

Financial Oversight Claims Payment Referral

- ❖ Health Plan Oversight received numerous stakeholder complaints regarding a plan's provider contracts and claims payment and processing issues
- ❖ Enforcement's investigation revealed numerous violations, including unfair contracting, administrative capacity, and untimely claims payment and processing errors
- ❖ The plan agreed to an overhauling corrective action plan that involved placing a monitor to oversee operations, hiring additional staff, restructuring its processes for better internal oversight, and paying a \$2 million administrative penalty

OFFICE OF PROVIDER OVERSIGHT



- ❖ Monitors the financial stability of Risk Bearing Organizations through the analysis of financial data
- ❖ Recommends meaningful and appropriate regulatory resolutions to claim payment disputes between health plans and providers
- ❖ Identifies unfair payment practices and unfair billing patterns

Alleged Overpayments Referrals

- ❖ Provider Complaint Unit received a complaint from the California Medical Association that a Plan engaged in unfair payment practices with providers
- ❖ Enforcement's investigation revealed complications between coordination of benefits with Medicare
- ❖ Discovery proved that the Plan failed to abide by overpayment notice requirements, as well as reimbursement deadlines and cut-off dates
- ❖ The Plan agreed to a \$50,000 administrative penalty and future corrective action plan

In-House Enforcement Investigations

- ❖ COBRA Benefits and HIPAA Options and Coverage
 - Undercover investigation to determine if plans were informing enrollees of their COBRA benefits and HIPAA options and coverage
 - Several plans failed to affirmatively market and offer guaranteed coverage under HIPAA and were assessed administrative penalties upwards of \$10,000 per violation
- ❖ Delays in Breast Cancer Treatment
 - One plan systematically delayed providing breast cancer treatment approved by Medicare and provided by all major competitors for several years
- ❖ Enrollee Billing Disputes
 - Enforcement spearheaded litigation to protect enrollees from balance billing, resulting in a published California Supreme Court decision (*Prospect Medical Center v. Northridge* (2009) 45 Cal.4th 497)

Questions?



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