



Network Adequacy Laws in Medi-Cal Managed Care Plans*

Managed Care in California Series

Issue No. 1

Prepared By: Abbi Coursolle

Introduction to Medi-Cal Managed Care structure in California

Millions of low-income Californians are enrolled in managed care plans statewide in Medi-Cal.¹ Over the past 30 years, California has increasingly moved more beneficiaries into a capitated managed care delivery system. Medi-Cal managed care is now statewide and approximately 70 percent of Medi-Cal enrollees receive services through a managed care plan, including high-risk and vulnerable groups like seniors, people with disabilities, pregnant women, and children.² In January, California expanded Medi-Cal to cover 1.9 low-income adults in the state, primarily using managed care plans to deliver services to the new enrollees.³

In Medi-Cal, managed care is delivered using different models in various counties. Under the Two-Plan model, enrollees have two health plans, one a publicly-run entity, a “local initiative,” and a privately-run entity, a “commercial plan,” from which to choose their care. Under the Geographic Managed Care (GMC) model, several commercial plans compete to provide services to Medi-Cal beneficiaries. Under the Regional Model, two privately-run plans compete to provide services to beneficiaries; these plans cover an entire region of the state as if it were one county. In Imperial and San Benito counties, one commercial plan is available to Medi-Cal beneficiaries who wish to enroll in managed care on a voluntary basis. And under the County Organized Health System (COHS) model, a county forms an agency which contracts with the state Medi-Cal program to provide services to almost all Medi-Cal beneficiaries living in that county.

Medi-Cal managed care plans are governed by both state and federal law, and are regulated by a number of federal and state agencies. Medi-Cal plans are regulated by the federal Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS). Most—but not all—Medi-Cal

* For information about network adequacy in Covered California plans, see our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #2: NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS. (2014).

managed care plans also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the “California Knox-Keene Act.”⁴ Because COHS Medi-Cal plans are exempt from DMHC licensure, only Health Plan of San Mateo, a COHS, is Knox-Keene licensed.⁵

Overview of Network Adequacy

Medi-Cal managed care plans are capitated – i.e. they receive a set payment per enrollee per month in exchange for providing services.⁶ The plans contract on a “comprehensive risk” basis, meaning they accept the risk of incurring a loss if they spend more on services than they receives through the capitated payments, but they will make a profit if providing services costs less than the payments.⁷ These arrangements give plans an incentive to limit coverage of services for their enrollees in order to maximize profits. Thus, strong legal protections are needed to ensure that enrollees have access to high quality, medically necessary services. Both federal and state laws require Medi-Cal managed care plans to have adequate provider networks. But the rules are differ depending on whether a plan is regulated by DMHC and DHCS, or only DHCS.

Federal Medicaid law requires that each Medi-Cal Managed Care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.⁸ The federal Medicaid regulations that implement this requirement provide the State with significant discretion to define network adequacy through state law or the managed care contracting process.⁹ These regulations require managed care plans that participate in Medi-Cal to ensure and document their capacity to serve the health care needs of their enrollees in each service area in accordance with state access-to-care standards.¹⁰ The documentation should demonstrate that the participating plans offer a range of primary, preventive and specialty services, and maintain a provider network sufficient in number, type and geographic distribution.¹¹ States must certify to CMS that the plans comply with state standards for service availability, after the state’s review of each plan’s documents.¹² California Medi-Cal law complies with the federal rules in part by requiring plans to “[e]nsure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area.”¹³

Numbers and Types of Providers

Federal Medicaid rules require plans to provide access to all covered services considering the expected utilization of services, given the specific health needs of Medicaid enrollees; and the number and types of providers, in terms of training, experience and specialization.¹⁴ In addition, the plan must demonstrate, to the state’s satisfaction, that it provides an “appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.”¹⁵ In addition, state law requires plans to “[e]nsure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area.”¹⁶ Consistent with federal requirements, Medi-Cal plans must provide female enrollees with direct access to women’s health specialists for routine and preventative services.¹⁷ Medi-Cal plans must also contract with any willing safety net provider in the area.¹⁸ Moreover, consistent with the Knox-Keene Act, California requires all Medi-Cal plans to meet a 1:1200 provider-patient ratio overall, and a 1:2000 ratio for

primary care providers.¹⁹ Plans must monitor the number of network providers not accepting new Medicaid patients as a way to ensure that sufficient in-network providers are available.²⁰ Plans must report to the state the capacity of their contracted providers on a monthly basis, or whenever there is a “significant change” to their network capacity.²¹

Geographic Access

Federal Medicaid regulations require plans to ensure that their networks are adequate considering the geographic location of providers and enrollees, in terms of distance/travel time.²² In calculating the appropriate distance and travel time requirements, plans must account for the means of transportation used by Medicaid enrollees.²³ Plans must also demonstrate to the state that their provider networks offer sufficient “geographic distribution” to provide access to covered services.²⁴ California complies with these requirements by mandating that plans to make primary care services available within 30 minutes or 10 miles of an enrollee’s residence, unless the state has approved an alternative standard.²⁵ Plans must report to the state the locations of their contracted providers on a quarterly basis, or whenever there is a “significant change” to their network.²⁶

Knox-Keene-licensed plans must meet additional time and distance standards for certain providers and services. Specifically, the plans must make available hospital services, and emergency care within 15 miles or 30 minutes of an enrollee’s home or workplace.²⁷ Plans must also ensure that ancillary services—that is, “laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider”—are available “within a reasonable distance” of primary care facilities.²⁸

Timely Access

Federal Medicaid rules require plans to provide enrollees with timely access to services.²⁹ States’ contracts with plans must ensure that plans meet the following requirements: comply with state rules on timely access to care and services, considering urgency of care; provide hours of operation no less than that offered to commercial enrollees or comparable to Medicaid fee-for service; when medically necessary, make services available 24 hours a day, 7 days a week; and, monitor provider compliance and take corrective action if needed.³⁰

California has complied with the federal requirements by incorporating the Knox-Keene Act timely access standards into its Medi-Cal managed care plan contracts for all plans.³¹ Those standards require plans to ensure that enrollees have access to services within the following timeframes: urgent care, where no prior authorization is required, within 48 hours of request;³² urgent care, where prior authorization is required, within 96 hours of request;³³ non-urgent care and primary care, within 10 business days of request;³⁴ non-urgent care specialty care, within 15 business days of request;³⁵ non-urgent non-physician mental health care, within 10 business days of request;³⁶ and non-urgent ancillary services, within 15 business days of request.³⁷ These times may be extended if the referring or treating provider determines that a longer wait time will not negatively impact the enrollee’s health.³⁸ Plans must also operate a 24/7 triage screening telephone line, and ensure that enrollees do not wait more than 30 minutes for screening by phone.³⁹ Knox-Keene-licensed plans must report on their compliance with these requirements on an annual basis.⁴⁰

Access to Services Out-of-Network

The federal Medicaid regulations and Medi-Cal contracts require that plans provide access to all covered services in a timely and adequate manner, including by providing access to out-of-network providers if no providers are available within a plan's network.⁴¹ In addition, plans must provide access to emergency care out-of-network, without requiring prior authorization.⁴² Plans must also provide for or arrange for enrollees to have access to in-network or out-of-network providers, respectively, for second opinions.⁴³ In California, Medi-Cal plans must also ensure that enrollees may access out-of-network family planning services without prior authorization, and plans must also offer access to out-of-network STD, and HIV testing services (though the plans may require prior authorization for those services).⁴⁴ Under California law, new Medi-Cal managed care enrollees also have a right to continue seeing an out-of-network provider from whom they'd previously received care in certain circumstances.⁴⁵ In all cases where plans approve out-of-network care, plans must coordinate payment with out-of-network providers to ensure that enrollees do not incur greater costs for seeing an out-of-network provider.⁴⁶

Options for Enrollees When Their Plan's Network Does Not Provide Access to Needed Services

When Medi-Cal managed care enrollees are not able to access a service they need through the managed care plan, they have several options to seek redress. First, the enrollee may file a grievance with the plan. Each Medi-Cal managed care plan has its own internal grievance process.⁴⁷ Plans generally have 30 days to resolve a grievance, but if the grievance concerns potential loss of life or limb, severe pain, or imminent & serious threat to health, the plan must resolve it within three days.⁴⁸ Second, enrollees in Knox-Keene-licensed plans may—after they have filed a grievance with the plan and have either received an unfavorable decision, or have waited 30 days without a decision (three days in expedited cases)—seek external review through DMHC.⁴⁹ Third, an individual may also request a Medi-Cal state hearing.⁵⁰ This request can be made at the same time the individual files a grievance with the plan. The individual may request a hearing up to 90 days after receiving a notice of action from the state or, if there is no notice, from the date she became aware of the action.⁵¹ Finally, at any point an enrollee may call or email the Medi-Cal Managed Care Ombudsman Office to report a problem with his or her plan's network.⁵²

As more low-income Californians, especially those with disabilities and chronic care needs, are enrolled in Medi-Cal managed care plans, consumer advocates must ensure that the plans' networks are adequate to provide all covered services. Consumer advocates should work with DHCS, DMHC, and policymakers to monitor and enforce California's strong consumer protections that aim to ensure access to services for Medi-Cal enrollees.

ENDNOTES

- ¹ CAL. DEPT. OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE ENROLLMENT REPORT – MARCH 2014 3 (2014) (Medi-Cal managed care enrollment as of March 2014 nearly 7 million), *available at* http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptMar2014.pdf.
- ² CAL. DEPT. OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE PERFORMANCE DASHBOARD 1 (2014) (managed care enrollment at 71% as of December, 2013), *available at* http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_Q4_2013.pdf.
- ³ Press Release, Covered Cal., Covered California's Historic First Open Enrollment Finishes with Projections Exceeded (Apr. 17, 2014), *available at* <http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html>.
- ⁴ See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.
- ⁵ CAL. WELF. & INST. CODE § 14087.95; see also, e.g., CAL. HEALTH BENEFITS REV. PROG., THE CALIFORNIA COST AND COVERAGE MODEL, App'x 13 at 7 (2013), *available at* http://www.chbrp.org/other_publications/docs/ap_13.pdf.
- ⁶ In Medi-Cal, the capitation rate is paid by the state to the plans directly. See CAL. HEALTH CARE FOUND., MEDI-CAL FACTS AND FIGURES: A PROGRAM TRANSFORMS 26 (2013), *available at* <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf>. There are a few very small managed care programs in Medi-Cal for enrollees with particular chronic conditions that are not capitated; this paper will not discuss them. See CAL. DEPT. OF HEALTH CARE SERVS., *supra* note 1 at 3.
- ⁷ See 42 C.F.R. § 438.2 (defining "comprehensive risk contract" and "capitation payment" for Medi-Cal plans).
- ⁸ 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to enrollees in Medicaid managed care organizations); *id.* § 438.207(b) (requiring State to ensure adequate network adequacy in Medicaid managed care plan contracts).
- ⁹ *Id.* §§ 438.206-07.
- ¹⁰ *Id.* § 438.207(a).
- ¹¹ *Id.* § 438.207(b).
- ¹² *Id.* § 438.207(d).
- ¹³ CAL. WELF. & INST. CODE § 14182(c)(2); see also, e.g., CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COHS COUNTIES, Ex. A, Att. 6 (2014), *available at* <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.
- ¹⁴ 42 C.F.R. § 438.206(b)(1)(ii)-(iii).
- ¹⁵ *Id.* § 438.207(b)(1).
- ¹⁶ CAL. WELF. & INST. CODE § 14182(c)(2); see also CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 6 (contract language requiring compliance with these provisions).
- ¹⁷ E.g., CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 14 § 4(D)(17); 42 C.F.R. § 438.206(b)(2).
- ¹⁸ CAL. WELF. & INST. CODE § 14182(c)(7); CAL. CODE REGS., tit. 22, § 53800(b)(2)(C)(1).
- ¹⁹ CAL. CODE REGS., tit. 22, § 53853(a); see also, e.g., CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 6 § 2.
- ²⁰ *Id.* § 438.206(b)(1)(iv).
- ²¹ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, at Ex. A, Att. 6 § 10; Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Mar. 12, 2014) (APL 14-006), *available at* <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-006.pdf>; see also Letter from Cal. Dep't of Health Care Services to All Two-Plan and Geographic Managed Care Health Plans (Apr. 14, 2011) (APL 11-09), *available at* <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-009.pdf>; CAL. CODE REGS., tit. 22, § 53852.
- ²² 42 C.F.R. § 438.206(b)(1)(v).
- ²³ *Id.*
- ²⁴ *Id.* § 438.207(b)(2).
- ²⁵ CAL. CODE REGS., tit. 22, § 53885(a); see also CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 6 § 7.
- ²⁶ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, at Ex. A, Att. 6 § 10; see also CAL. CODE REGS., tit. 22, § 53852.
- ²⁷ CAL. CODE REGS., tit. 28, § 1300.51(c)(H)(i)-(ii).

²⁸ *Id.* § 1300.51(c)(H)(iv).

²⁹ 42 C.F.R. § 438.206(c)(1).

³⁰ *Id.* § 438.206(c)(1).

³¹ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 9 § 3(A).

³² CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(5)(A).

³³ *Id.* § 1300.67.2.2(c)(5)(B).

³⁴ *Id.* § 1300.67.2.2(c)(5)(C).

³⁵ *Id.* § 1300.67.2.2(c)(5)(D).

³⁶ *Id.* § 1300.67.2.2(c)(5)(E).

³⁷ *Id.* § 1300.67.2.2(c)(5)(F).

³⁸ *Id.* § 1300.67.2.2(c)(5)(G).

³⁹ *Id.* § 1300.67.2.2(c)(8).

⁴⁰ *Id.* § 1300.67.2.2(g).

⁴¹ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 9 § 16; 42 C.F.R. § 438.206(b)(4).

⁴² 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114(b)-(c); *see also* CAL. CODE REGS., tit. 22, §§ 53216, 53855; CAL. CODE REGS., tit. 28, § 1300.67(g) (comparable provisions in Knox-Keene Act regulations). Plans must also cover post-stabilization care in certain circumstances. *See* 42 U.S.C. § 1395w-22 (d)(2); 42 C.F.R. §§ 438.114(b), (e); CAL. CODE REGS., tit. 22, § 53855(c).

⁴³ 42 C.F.R. § 438.206(b)(3); CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 5 § 1(C).

⁴⁴ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 9 §§ 9(A)-(C).

⁴⁵ CAL. WELF. & INST. CODE § 14182(b)(13); *see* NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN MEDI-CAL (2013), *available at* <http://www.healthlaw.org/publications/search-publications/continuity-of-care-in-medi-cal>.

⁴⁶ 42 C.F.R. § 438.206(b)(5); CAL. CODE REGS., tit. 22, §§ 51002, 53855(c). Providers of emergency services to Medicaid managed care enrollees must accept the state's fee-for-service rate for services to Medicaid enrollees. 42 U.S.C. § 1396u-2(b)(2)(D).

⁴⁷ For information about filing an internal plan grievance, *see* our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #5: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (forthcoming 2014); *see also* HEALTH CONSUMER ALLIANCE, WHAT TO DO IF YOU HAVE A PROBLEM WITH YOUR MEDI-CAL HEALTH PLAN 1-2 (2008) *available at* <http://healthconsumer.org/fso46LAeng.pdf>.

⁴⁸ CAL. HEALTH & SAFETY CODE § 1368.01; *see also* CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 13 at Ex. A, Att. 14 §§ 5-6.

⁴⁹ CAL. HEALTH & SAFETY CODE §§ 1368(b)(1)(A), 1374.30. Most complaints about network adequacy will be resolved through DMHC's complaint process, but cases involving disputes over the medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational may be sent to a clinical review process known as Independent Medical Review (IMR). *See id.* § 1374.30. For information about requesting external review, *see* our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #5: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (forthcoming 2014); *see also* HEALTH CONSUMER ALLIANCE, *supra* note 50 at 2-3.

⁵⁰ 42 C.F.R. § 431.220; 22 CCR § 50951. For information about requesting a fair hearing, *see* our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #5: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (forthcoming 2014); *see also* HEALTH CONSUMER ALLIANCE, *supra* note 50 at 3-4; HEALTH CONSUMER ALLIANCE, WHAT IF MEDI-CAL SAYS "NO"? (2008), *available at* <http://healthconsumer.org/fsoo2LAeng.pdf>.

⁵¹ 42 C.F.R. § 431.221(d); CAL. WELF. & INST. CODE § 10951; *see also Morales v. McMahon*, 223 Cal. App. 3d 184 (1990).

⁵² *See* Cal. Dep't of Health Care Servs., Medi-Cal Managed Care Division Office of the Ombudsman, <http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx> (last visited Jun. 17, 2014).