



Department of Health Care Services

Although Its Oversight of Managed Care Health Plans Is Generally Sufficient, It Needs to Ensure That Their Administrative Expenses Are Reasonable and Necessary

April 2019

REPORT 2018-115





CALIFORNIA STATE AUDITOR

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April 4, 2019
2018-115

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this report detailing our audit of the Department of Health Care Services' (DHCS) oversight of the Health Plan of San Joaquin (San Joaquin) and other similar Medi-Cal managed care health plans (health plans) with which DHCS contracts for the provision of quality health care to Medi-Cal beneficiaries. This report concludes that DHCS provides sufficient oversight to ensure that health plans meet state and federal quality of care requirements. However, DHCS does not provide some important oversight and guidance to health plans, such as guidance concerning which administrative expenses are reasonable and necessary.

We found that DHCS' processes for ensuring that health plans provide quality of care at a level consistent with state and federal requirements are appropriate. DHCS requires health plans to engage in an improvement process known as a quality corrective action plan (quality CAP) when they fail to meet quality of care standards specified in state regulations. DHCS properly identified those health plans that met its criteria to be placed on a quality CAP, required them to conduct activities aimed at improving quality, conducted appropriate monitoring activities to ensure that the health plans' actions addressed the identified deficiencies, and took appropriate steps when they did not achieve the goals of the quality CAPs.

However, we did find several aspects of DHCS' oversight that it could improve. It does not consistently ensure that health plans have proper processes in place to prevent, identify, and address fraud, and it does not evaluate whether health plans have controls in place to prevent conflicts of interest. Additionally, DHCS does not provide health plans with guidance on what types of administrative expenses are reasonable and necessary, which likely contributed to the health plans we reviewed making some questionable expenditures. Finally, we reviewed the employee bonuses paid by three health plans and found that, although health plans are allowed to use Medi-Cal funds to pay reasonable employee bonuses, DHCS does not oversee whether such bonuses are reasonable.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CAP	corrective action plan
EQRO	external quality review organization
HEDIS	Healthcare Effectiveness Data and Information Set
MPL	minimum performance level

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SUMMARY

The Department of Health Care Services (DHCS) is responsible for administering the California Medical Assistance Program, known as Medi-Cal. Managed care is one method DHCS uses to provide Medi-Cal benefits, and to do so, it contracts with Medi-Cal managed care health plans (health plans) and pays them a monthly premium to provide quality health care services to Medi-Cal beneficiaries. These contracts require health plans to meet quality of care standards specified in state regulations. When health plans fail to meet the quality of care standards, such as not providing required or timely medical treatments for diabetes and postpartum care, DHCS requires them to engage in an improvement process to correct deficiencies known as a quality corrective action plan (quality CAP). State regulations also generally require DHCS to ensure that a health plan's overall administrative expenses do not exceed 15 percent of its revenue and are reasonable and necessary. For this audit, we reviewed DHCS' oversight of the Health Plan of San Joaquin (San Joaquin) and a selection of other health plans as it relates to their quality of care and administrative expenses. This report draws the following conclusions:

DHCS' Processes to Oversee Health Plans' Quality of Care Are Generally Sufficient

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DHCS provides sufficient oversight to ensure that health plans meet state and federal quality of care requirements. DHCS properly placed four poorly performing health plans on quality CAPs between 2013 and 2017, ensured that the health plans' actions addressed identified deficiencies, and adequately monitored each plan's progress in implementing its CAP. For example, as part of its quality CAP process, DHCS conducts several monitoring activities—such as holding periodic meetings with health plans to gauge their progress in achieving specified goals—to ensure that health plans address quality of care deficiencies. Although two of the four health plans on quality CAPs successfully fulfilled the respective requirements, and the remaining two health plans did not, we found that DHCS took the appropriate steps—which included imposing financial sanctions—to address these health plans' shortcomings. However, DHCS is missing an opportunity to identify successful actions taken by health plans to address deficiencies that it can share with all health plans. Specifically, DHCS requires health plans to conduct activities, known as performance improvement projects, as part of their quality CAPs to increase performance in areas in which they are deficient, but it does not follow up to identify successful projects or periodically share these projects with other health plans.

Page 25**DHCS Does Not Ensure That Health Plans' Administrative Expenses Are Reasonable and Necessary**

Contrary to federal and state regulations, DHCS does not provide health plans with guidance on what types of administrative expenses are reasonable and necessary, and it limits its oversight of health plans' administrative expenses to generally ensuring that they do not exceed the maximum of 15 percent of the Medi-Cal funds health plans receive that state regulations typically allow. Our review determined that each of the health plans had questionable expenditures among their administrative expenses, such as events for their employees, that used Medi-Cal funding. DHCS also does not oversee, or provide guidance on, health plans' bonus programs to ensure that they are reasonable. Thus, without providing specific direction to the health plans, DHCS risks that health plans are making administrative expenditures that are not reasonable and necessary.

Page 31**DHCS Properly Recouped Excess Funds From Health Plans**

We also reviewed whether DHCS complied with federal requirements in recouping excess funds it paid to health plans during the first three years of expanded coverage resulting from the federal Patient Protection and Affordable Care Act. We determined that DHCS' actions to recoup nearly \$2.6 billion in Medi-Cal overpayments to health plans complied with the federally approved methodology.

Summary of Recommendations

To help identify successful performance improvement projects, DHCS should identify best practices by December 2019 and follow up on whether health plans implement and expand successful projects.

DHCS should develop and issue binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses. Further, it should provide guidance to the health plans on what is a reasonable bonus program.

Agency Comments

DHCS largely agreed with our recommendations, but did not fully agree to implement our recommendation that it develop and issue guidance to the health plans on what constitutes reasonable and necessary administrative expenses, or that it issue guidance regarding what is a reasonable bonus program. Although we did not make any recommendations to the Santa Clara Family Health Plan, it chose to submit a response in which it disagreed with our conclusion that some of its administrative expenses were questionable.

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INTRODUCTION

Background

The federal Medicaid program, overseen by the Centers for Medicare & Medicaid Services (CMS), provides health coverage to certain low-income individuals and families who meet federal and state eligibility requirements. California participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal. The Department of Health Care Services (DHCS) is the single state agency responsible for administering Medi-Cal. As of October 2018, the Medi-Cal program provided services to nearly 12 million beneficiaries—nearly one-third of Californians. DHCS received more than \$110 billion in federal and state funds during fiscal year 2017–18 to administer the Medi-Cal program, with \$19 billion of that total coming from California’s General Fund.

The State provides Medi-Cal benefits through two delivery systems: fee-for-service and managed care. Under fee-for-service, medical providers bill DHCS directly for approved services they provide to Medi-Cal beneficiaries. In Medi-Cal managed care, DHCS contracts with Medi-Cal managed care health plans (health plans) and pays each a monthly capitation payment (premium)—an amount per person covered—to provide health care to Medi-Cal beneficiaries. During the entire period covering fiscal years 2013–14 through 2017–18, DHCS contracted with 22 health plans. These contracts require health plans to meet quality of care and financial operating standards specified in state regulations. Each health plan uses the premium to fund both health care services and its administrative expenses, such as salaries and facility maintenance. Additionally, DHCS issues guidance to health plans, such as that related to contract or legal requirements, in the form of All-Plan Letters. These letters undergo a similar review and approval process as state regulations in that DHCS is required to solicit feedback from the health plans and the public before issuing the guidance.

DHCS Is Responsible for Overseeing Health Plans’ Quality of Care

Federal and state regulations require DHCS to measure and report on the quality of care that the health plans provide to Medi-Cal beneficiaries. To fulfill this requirement, DHCS contracts with an external quality review organization (EQRO) to perform annual independent reviews of the services health plans provide. For these external quality reviews, the EQRO evaluates the health plans annually using a subset of the performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS).¹ HEDIS is a nationally recognized set of more than 90 performance measures used to evaluate health plans’ performance on providing important health care services, such as the type and frequency of medical exams for diabetes care. In its evaluation, the EQRO determines the health plan’s performance for each of the HEDIS measures it reviews. More than 90 percent of U.S. health plans use these performance measures. By using this standardized national measure of quality of care that is independently evaluated, DHCS can compare a health plan’s performance against other health plans in California as well as those in other states.

¹ The National Committee for Quality Assurance, an independent nonprofit organization, develops the HEDIS measures and conducts accreditation assessments of health plans.

Additionally, state regulations require DHCS to conduct its own review to assess the quality of care that each health plan provides. In its annual quality review, DHCS selects roughly 20 of the more than 90 HEDIS performance measures and uses them to evaluate the quality of care that health plans deliver to beneficiaries.

DHCS updates its selection of HEDIS performance measures to use in quality of care assessments each year after consulting with the health plans, the EQRO, and various stakeholders. These performance measures include what are known as quality indicators to evaluate a health plan's performance on each measure. Some examples of quality indicators include assessing whether beneficiaries with diabetes receive required eye exams and blood tests, or evaluating whether beneficiaries who have recently given

birth receive timely postpartum care. To create a standard for assessing health plans' quality performance, DHCS creates a minimum performance level (MPL), which is based on how health plans nationally are performing, for each of the quality indicators it selects. DHCS considers health plans that score higher on a quality indicator than at least 25 percent of health plans nationwide to be performing above the MPL on the performance measure. If the health plan demonstrates one or more of the deficiencies shown in the text box, DHCS requires the health plan to engage in a process known as a corrective action plan (CAP), referred to as a *quality CAP*, to improve the quality of care it provides.

DHCS Places Health Plans on Quality CAPs if One or More of the Following Situations Occur:

- The plan has 50 percent or more of its quality indicators below the MPL in a given year.
- The plan has three or more of the same quality indicators below the MPL for three or more consecutive years.
- DHCS determines, based on other factors it finds concerning, that a health plan's performance warrants a quality CAP.

Source: DHCS' policies and procedures for its quality CAP process.

As part of the quality CAP process, DHCS requires the health plan to describe key staff, resources, and initiatives it will use to improve its performance for each quality indicator identified in the quality CAP. Additionally, the quality CAP process includes the health plan meeting with DHCS management periodically to discuss the plan's progress on implementing the quality CAP to ensure compliance. The EQRO approves and provides technical assistance on certain quality improvement activities—including performance improvement projects—the health plans undertake as part of their quality CAPs. Performance improvement projects consist of a health plan evaluating the effectiveness of small changes to improve quality of care. In addition to DHCS requiring a health plan to implement performance improvement projects as part of the quality CAP, it also requires the health plan to meet annual quality improvement milestones. DHCS may extend the duration of the quality CAP and also may impose consequences that include monetary sanctions if a health plan fails to meet one or more of the yearly quality improvement milestones it agreed to as part of the quality CAP.

As part of this audit, we reviewed DHCS' oversight of the four health plans that were on quality CAPs between 2013 and 2017: Anthem Blue Cross Partnership Plan (Anthem), Health Net Community Solutions, Inc. (Health Net), Health Plan of San Joaquin (San Joaquin), and Molina Healthcare of California Partnership Plan, Inc. (Molina). In addition, we selected two health plans—Kern Health Systems (Kern) and Santa Clara Family Health Plan (Santa Clara)—that were not on quality CAPs but have organizational structures similar to that of San Joaquin. We visited these two health plans as well as San Joaquin to review whether their administrative expenses were reasonable and necessary. Figure 1 on the following page shows all six health plans we reviewed and the counties they serve throughout California.

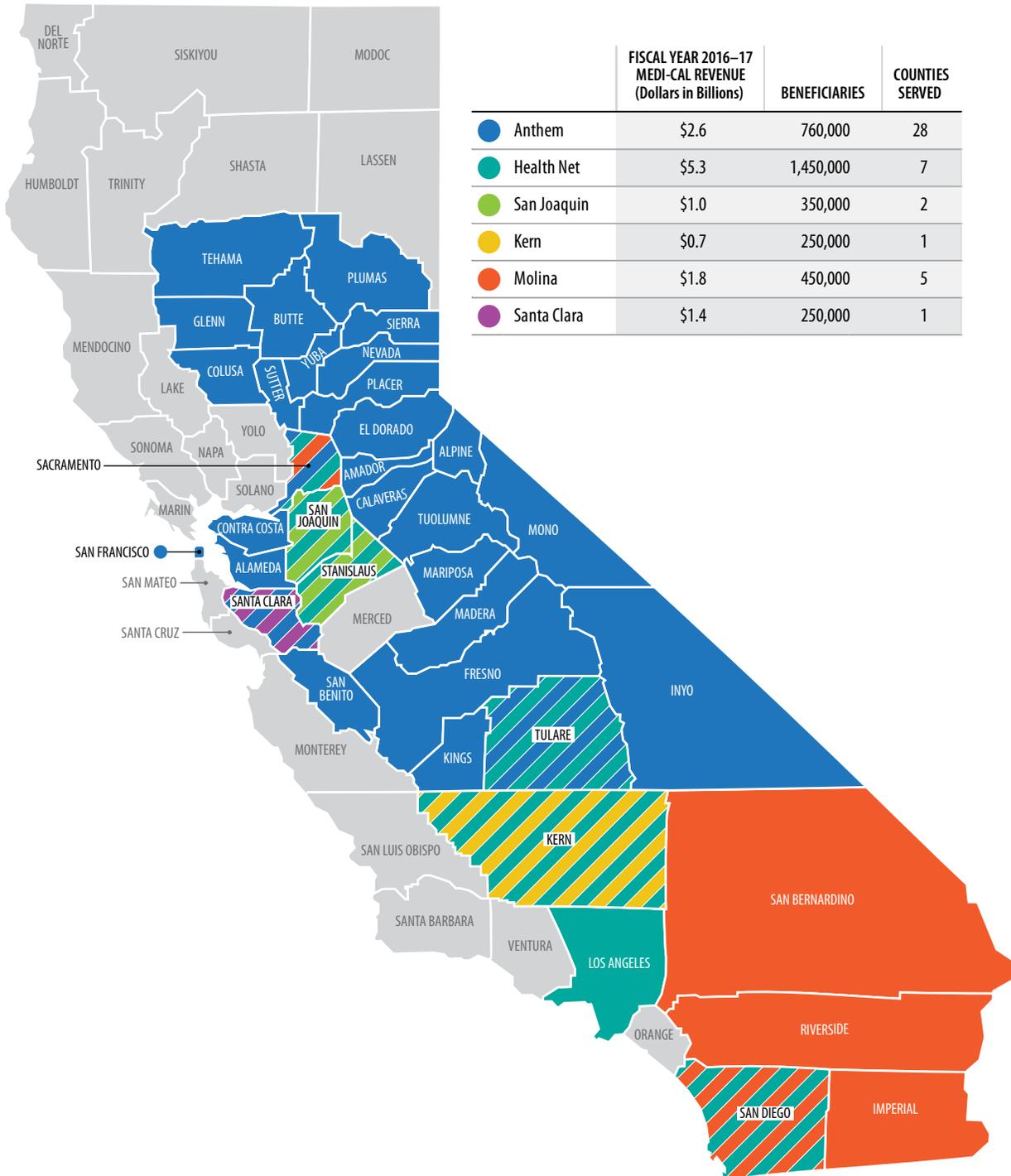
State law requires DHCS to perform annual medical audits of prepaid health plans, which include the Medi-Cal managed care health plans we reviewed, for compliance with requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), which sets operating standards for the licensing of most California managed care plans. The text box identifies the seven audit categories that DHCS uses to evaluate the health plans' compliance with key requirements during its annual medical audits. For example, the category of "administrative and organizational capacity" includes steps to review a health plan's fraud detection procedures—a Knox-Keene Act requirement. Deficiencies discovered in an audit can also result in health plans being placed on a CAP, which for the purposes of this report we refer to as an *audit CAP*. Similar to its requirements for the quality reviews, DHCS requires a health plan to submit an audit CAP detailing how it will address the deficiencies identified through the audit. DHCS requires health plans to either correct audit deficiencies within 30 calendar days from completion of the audit report or specify the intended date of completion in the audit CAP. DHCS may impose administrative or financial sanctions on health plans that fail to address the deficiencies listed in the audit CAP. Further, DHCS indicated that it monitors a health plan's compliance with an audit CAP through regular communication and by verifying supporting documentation the health plan supplies to show how it is addressing the audit deficiencies.

DHCS Reviews Seven Categories as Part of Its Annual Medical Audits

- Utilization management
- Case management and coordination of care
- Access and availability of care
- Member rights
- Quality management
- Administrative and organizational capacity
- State supported services

Source: DHCS.

Figure 1
The Health Plans We Reviewed Serve Counties Throughout California



Source: DHCS' September 2018 health plan data.

Note: The health plans we reviewed do not serve the counties shaded in gray.

Health Plans Must Meet Certain Requirements Related to Their Administrative Expenses

State regulations generally require DHCS to ensure that a health plan's overall administrative expenses do not exceed 15 percent of the Medi-Cal funds it receives. Administrative expenses are generally considered to be any costs not directly related to providing health care services to beneficiaries. Although state regulations require that administrative expenses be reasonable and necessary, and define some general categories of administrative expenses—such as salaries and bonuses, marketing, and legal expenses—state regulations do not provide specific guidance on what constitutes a reasonable and necessary administrative expense. This leaves health plans to rely on their own judgment to determine whether their administrative expenses are “reasonable and necessary.”

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DHCS' Processes to Oversee Health Plans' Quality of Care Are Generally Sufficient

Key Points

- DHCS has sufficient processes to monitor the quality of care that health plans provide and to address health plans that are performing poorly.
- The majority of all health plans in the State perform at levels that meet or exceed those established by DHCS for quality of care. Although two of the four health plans on quality CAPs have not demonstrated sufficient improvement, DHCS has taken appropriate steps to address these health plans' inadequate performance.
- DHCS does not consistently ensure that health plans have proper processes in place to prevent, identify, and address fraud. Additionally, DHCS does not evaluate whether health plans have controls in place to prevent conflicts of interest.

DHCS Has Adequate Processes to Oversee Health Plans' Quality of Care

DHCS' processes for ensuring that health plans provide quality of care at a level consistent with state and federal requirements are appropriate. State regulations require health plans to provide quality care and DHCS requires health plans to meet or exceed the MPL it establishes for each quality indicator. In addition, federal regulations require DHCS to annually review the health plans' quality assessment and efforts that the plans make to improve performance in the way they deliver services to beneficiaries. Federal regulations also direct DHCS to require health plans to complete performance improvement projects when it identifies poor performance.

As described in the Introduction, DHCS monitors whether health plans meet or exceed the established MPLs. When it identifies that a plan is consistently performing below the MPLs, DHCS generally places it on a quality CAP and then monitors its performance until the health plan meets the requirements of the CAP. Of the 22 health plans in the State that offered Medi-Cal coverage during fiscal year 2016–17, four—Anthem, Health Net, Molina, and San Joaquin—were on quality CAPs. Based on our review of the four health plans' performances in meeting or exceeding the MPLs during 2013 through 2017, we found that DHCS properly identified that these health plans met its criteria to be placed on a quality CAP. For instance, DHCS placed San Joaquin on a quality CAP in 2016 because it failed to meet 50 percent of the MPLs for the 22 quality indicators DHCS established for 2015.

Once DHCS identifies that it should place a health plan on a quality CAP, it identifies the milestones the health plan needs to achieve and requires that the health plan submit a response to the quality CAP that includes the specific activities it will take to address the poor performance. Based on a selection of these activities, we found that DHCS ensured that each of the four health plans conducted the quality improvement activities

their quality CAPs required in order to meet or exceed the MPLs. These activities included the health plans conducting two types of performance improvement projects. Although one type of these projects is lengthier than the other and involves a thorough review by the EQRO, they share the common goal of improving health care outcomes and processes by piloting small changes rather than implementing one large transformation.

For the lengthier type of improvement projects that we reviewed, DHCS provided documentation demonstrating that the EQRO reviewed and approved them. For example, in 2016 Molina submitted a proposal for an improvement project with the objective of increasing its performance related to annual monitoring of patients on persistent medications (monitoring persistent medications). According to DHCS, this monitoring addresses patient safety by assessing the percentage of adult beneficiaries who were prescribed one of several different medications commonly associated with conditions such as high blood pressure and diabetes for at least six months during the year and who also received at least one monitoring lab test during the year. Health plans perform this monitoring to reduce the likelihood of patient injury and limit increased health care costs that might occur due to complications from the medications. The EQRO did not initially approve Molina's proposal and required it to clarify the steps it proposed to increase the percentage of beneficiaries tested for adverse drug reactions before the EQRO ultimately approved the proposal. By including the EQRO's evaluation of the proposed actions included in a health plan's quality CAP, we found that DHCS has increased assurance that the activities the health plan undertakes to improve the quality of care are appropriate.

We also found that DHCS appropriately monitored the progress all four health plans made in developing and implementing the specified activities in their quality CAPs. From September 2015 through September 2017, DHCS' quality CAP process required health plans to participate in monthly meetings with a DHCS nurse consultant to discuss progress and provide technical assistance. In October 2017, DHCS began requiring health plans to also participate in quarterly in-person meetings with DHCS leadership to discuss and receive updates from the health plans on their progress in achieving the requirements of their CAPs.

Prior to attending these quarterly meetings, health plans must submit written reports to DHCS that discuss the progress they have made, any barriers to success, and the next steps that will be taken in the CAP process. DHCS explained that it uses these progress reports to update DHCS staff and executives on the health plan's progress and to inform the discussion at quarterly meetings. DHCS also uses the reports to prompt health plans to consider how staffing and other considerations may affect their planned efforts to improve quality of care. DHCS

stated that it had been holding quarterly meetings and requiring health plans to submit similar progress reports before it formally incorporated these steps as requirements in its October 2017 policy.

Based on our review of the quarterly meetings and progress reports for each of the four health plans, we found that DHCS held the required meetings and was able to demonstrate that the health plans submitted the required progress reports. Although DHCS is following its quality CAP process and the process is sufficient, it does not always guarantee success. As we describe in the next section, two of the four health plans—Health Net and San Joaquin—failed to achieve the requirements included in their 2017 quality CAPs.

We also reviewed another oversight mechanism, annual medical audits, that DHCS uses to determine whether health plans are complying with contract requirements. We found that DHCS' medical audit processes for having health plans address deficiencies and for working with plans to ensure a high level of care are adequate. During the required medical audits that DHCS conducted of the four health plans for the review period beginning in 2014 and ending in 2017, DHCS identified 16 findings related to quality of care. When we reviewed a selection of seven of these findings for which the audit CAP process was complete, we found that DHCS appropriately required the respective health plans to submit an audit CAP to address these findings. Further, DHCS' policies require that it assess whether a health plan's proposed actions will address its findings and meet applicable requirements. We found that each of the health plans' proposed actions addressed the findings, and DHCS subsequently closed the audit CAPs.

Some Health Plans on Quality CAPs Have Demonstrated Improvement in Their Quality of Care

The majority of health plans in the State generally met or exceeded most, if not all, of the MPLs for DHCS' established quality indicators in 2017. Based on the most recent data available as of January 2019, we determined that 16 of 22 health plans met or exceeded the MPLs on more than 85 percent of the 21 quality indicators during 2017.² One of these 16 health plans was Molina, which improved its performance and successfully completed its quality CAP in September 2018. In addition, because it improved its performance in certain locations that DHCS specified in its quality CAP, Anthem also successfully completed its quality CAP in September 2018. The improved performance by these health plans suggests that the

² Several health plans have multiple locations, and each location's performance can vary. This analysis is based on the average of a health plan's performance across all of its locations.

quality CAP process may be effective in increasing quality of care. Nonetheless, two other health plans—Health Net and San Joaquin—did not demonstrate similar improvement in their performance and remained on quality CAPs as of January 2019.

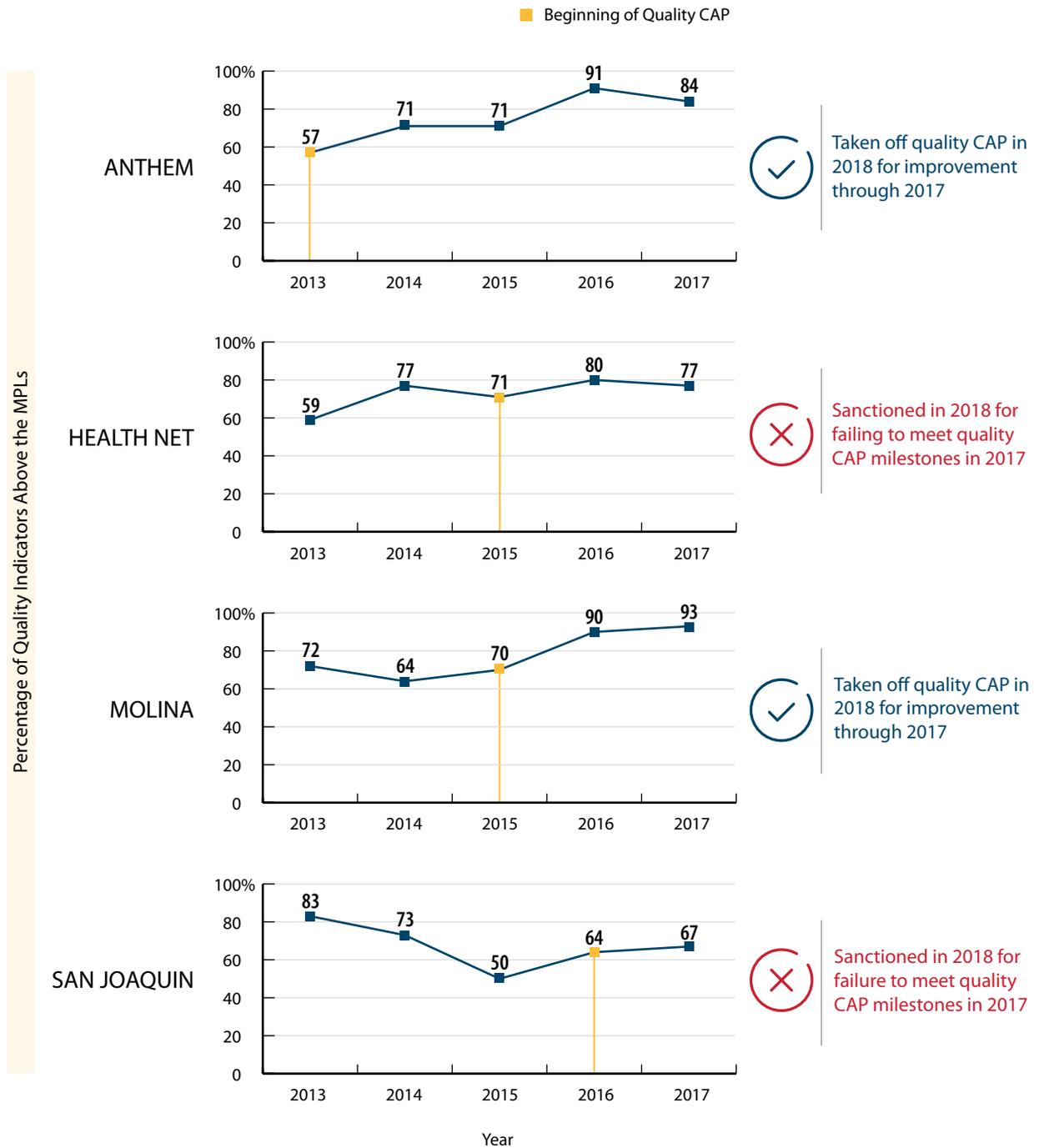
According to DHCS, when Anthem was placed on a quality CAP in 2013 a formal process had not yet been established for identifying poorly performing health plans and placing them on quality CAPs. DHCS formalized its quality CAP process in September 2015, and in December 2015 DHCS also placed Molina on a quality CAP. Figure 2 shows that Anthem and Molina improved their performance by 2017. Subsequently, DHCS removed them from the quality CAP.

In contrast, although Health Net and San Joaquin demonstrated some improvement after DHCS placed them on quality CAPs, both health plans fell short of meeting their quality CAP requirements. In the case of Health Net, it did not achieve the milestone for 2017 that it meet or exceed the MPLs for 82 percent of the quality indicators. Similarly, in 2017 San Joaquin fell short of its milestone that it meet or exceed the MPLs for 77 percent of the quality indicators. According to DHCS, both of these health plans operate in difficult-to-serve areas, and improvement projects that had worked elsewhere failed in these particular locations, making it difficult for the plans to improve their quality indicators sufficiently.

Although Health Net and San Joaquin demonstrated some improvement after DHCS placed them on quality CAPs, both health plans fell short of meeting their quality CAP requirements.

Because the health plans did not meet the quality CAP requirements, DHCS imposed monetary sanctions in October 2018 of \$335,000 on Health Net and \$135,000 on San Joaquin. State law allows DHCS to sanction the health plans \$5,000 for the first contract violation—an example of which is failing to maintain quality indicators above the MPLs—and \$10,000 for each subsequent violation. DHCS calculated the sanction amounts based on the number of quality indicators for which the health plans failed to meet or exceed the respective MPLs. In addition, DHCS required both health plans to submit revised quality CAPs detailing how they will meet or exceed the required milestones in 2019. DHCS will continue to monitor both plans until they achieve their quality CAP requirements.

Figure 2
Anthem and Molina Generally Improved Their Performance While on a Quality CAP



Source: Documentation related to quality CAPs and sanctions, and data provided by DHCS.

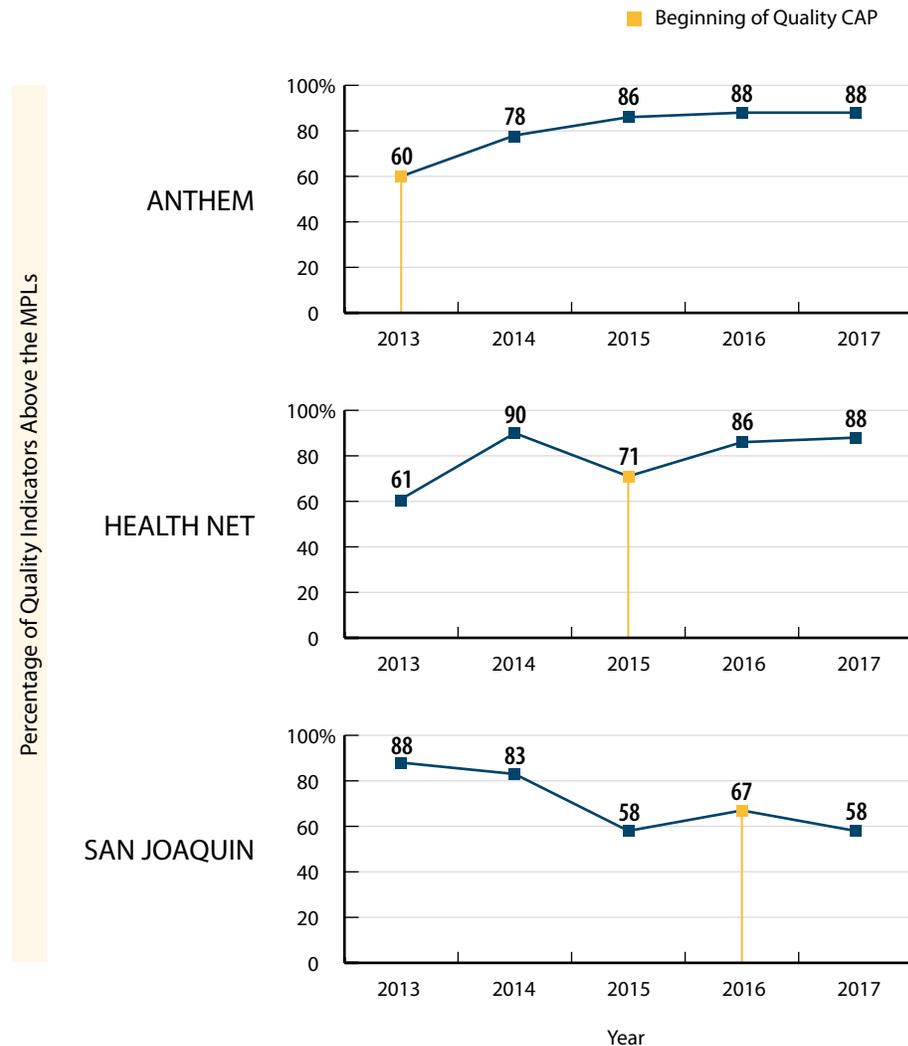
Note: DHCS places health plans on a quality CAP based on their previous performance.

In addition to reviewing health plans' overall performance, we also reviewed their performance on quality indicators related to three specific areas of care. The Joint Legislative Audit Committee (Audit Committee) specifically asked us to review quality of care standards related to postpartum care and diabetes treatments. We also selected for review the quality of care standards related to the area of monitoring persistent medications. Although our review found that health plans improved their performance in some of these areas, it is important to note that DHCS generally bases its decision to place health plans on, and remove them from, quality CAPs on overall performance rather than performance on quality indicators related to specific areas of care. DHCS placed three health plans—Anthem, Health Net, and San Joaquin—on quality CAPs, in part for their poor performance on certain quality indicators in the area of diabetes care. In 2013, DHCS held health plans accountable for eight quality indicators related to diabetes care. During the next four years, from 2014 through 2017, DHCS held the health plans accountable for six quality indicators related to diabetes care. Figure 3, which depicts the health plans' performance across these indicators, shows that both Anthem and Health Net improved their performance in this area over the course of their quality CAPs.

All three health plans conducted improvement projects to increase their performance on some of these diabetes-related quality indicators. For example, in 2016 Health Net implemented a successful outreach effort in a Sacramento clinic that led to an increase in beneficiaries with diabetes who received necessary blood tests. Health Net stated that it intended to adopt the use of this process at this location. Similarly, although San Joaquin's performance generally declined in the area of diabetes care, the health plan conducted a successful improvement project that increased one of its clinics' rate of beneficiaries with diabetes who received an eye exam, which led to it exceeding its intended goal for this project. This improvement project likely played a role in San Joaquin's performance on this quality indicator increasing from below the MPL to above the MPL in 2017 in the county in which it conducted the improvement project.

Of the three health plans that were on quality CAPs related to postpartum care—Anthem, Molina, and Health Net—two demonstrated improvement in providing timely postpartum care. Most notably, at the beginning of its quality CAP in 2013, Anthem met or exceeded the MPLs for just 33 percent of the quality indicators in this area. However, as Figure 4 on page 18 shows, Anthem improved its performance and in 2017 met or exceeded the MPLs for 92 percent of the quality indicators in providing timely postpartum care. Further, Figure 4 shows that Molina also demonstrated some improvement while on a quality CAP. Conversely, Health Net's performance decreased in 2017, despite being on a quality CAP.

Figure 3
Two of the Health Plans on a Quality CAP for Poor Performance in Quality Indicators Related to Diabetes Demonstrated Improvement

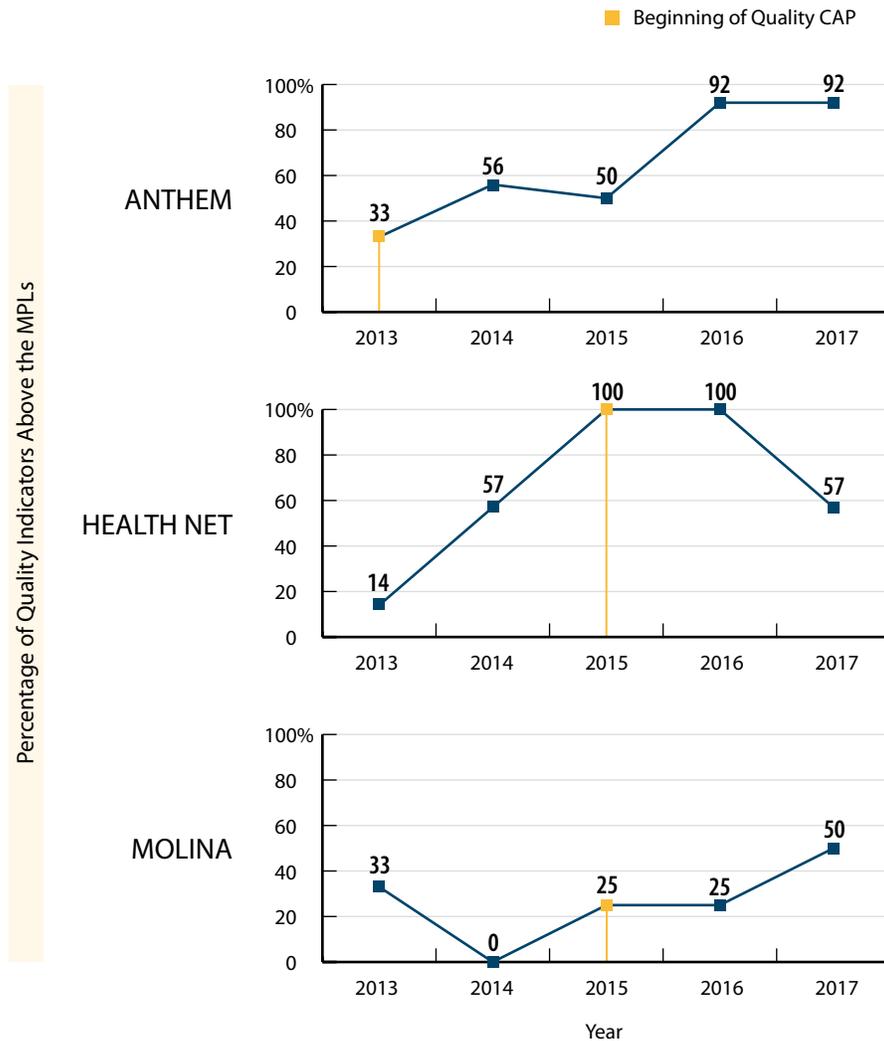


Source: Documentation related to quality CAPs and data provided by DHCS.

Note: DHCS places health plans on a quality CAP based on their previous performance.

Each of these plans implemented improvement projects aimed at increasing their performance in providing timely postpartum care. In a project conducted from 2016 through 2017 at four of its Sacramento clinics, Molina contacted new mothers to schedule and complete in-home assessment visits to help ensure that they received timely postpartum care. After implementing the project, Molina surpassed its initial goal for increasing the number of women completing timely postpartum visits. Molina stated that it planned to make the program permanent in this group of Sacramento clinics and would consider expanding the project to another clinic group in Sacramento County.

Figure 4
Two of Three of the Health Plans on Quality CAPs for Poor Performance on Timely Postpartum Care Demonstrated Improvement

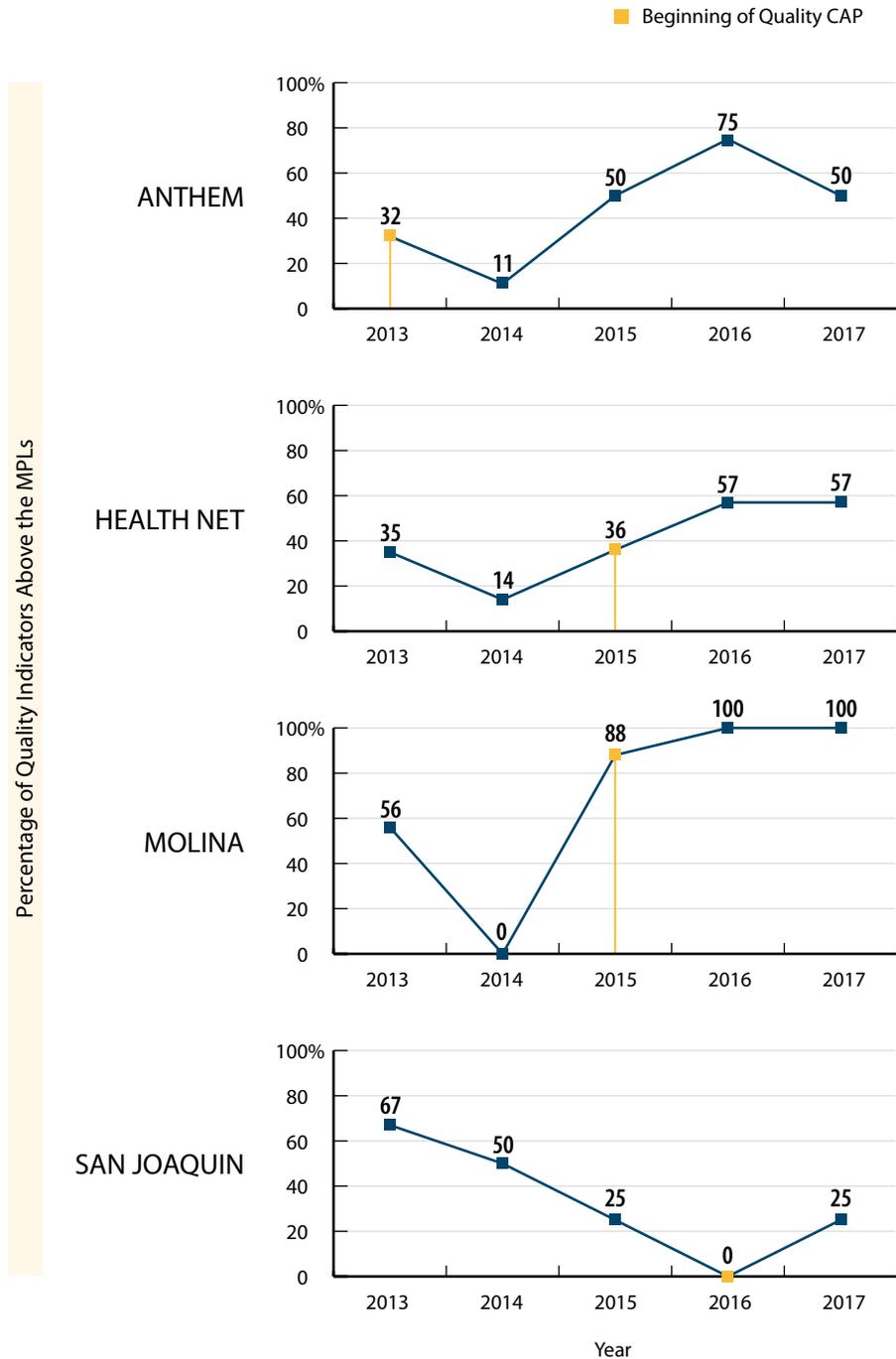


Source: Documentation related to quality CAPs and data provided by DHCS.

Note: DHCS places health plans on a quality CAP based on their previous performance.

The four health plans on quality CAPs for monitoring persistent medications showed some improved performance in meeting the MPLs. For example, Figure 5 shows that Health Net's performance in this area increased from 14 percent of quality indicators above the MPLs in 2014—the year that triggered the quality CAP—to 57 percent of quality indicators above the MPLs in 2017. Although Figure 5 shows that San Joaquin's performance related to monitoring persistent medications improved from 2016 to 2017, San Joaquin will continue on a quality CAP and DHCS will require that it complete additional improvement projects in this area.

Figure 5
 The Four Health Plans Demonstrated Improvement on Their Quality Indicators Related to Monitoring Persistent Medications Since Being Placed on a Quality CAP



Source: Documentation related to quality CAPs and data provided by DHCS.

Note: DHCS places health plans on a quality CAP based on their previous performance.

As part of their quality CAPs, these four health plans performed a variety of improvement projects for monitoring persistent medications, and those that were successful likely contributed to improvements in this area. For example, Anthem completed an improvement project that focused on outreach and intervention in two of its facilities in Tulare County that led to an increased percentage of beneficiaries who received necessary laboratory tests. As a result of its success, Anthem stated that it plans to expand the improvement project to other facilities and providers in Tulare County. In another successful example, in 2017 Health Net conducted an improvement project focused on increasing the number of beneficiaries of a clinic in Sacramento County who had completed their annual laboratory testing. Based on the outreach efforts performed, Health Net stated that it increased the number of beneficiaries who completed annual laboratory testing, and it concluded that the improvement project was a success and one that it would continue.

Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality CAPs, it is missing an opportunity to ensure that health plans formally adopt successful projects and to share these with other plans. Specifically, once an improvement project reaches its completion, the health plan can choose to adopt or abandon the project. If a health plan chooses to adopt the improvement project, it may do so at only the location where it was completed or it may expand the project to other locations. In instances in which improvement projects are successful and the health plans indicate they will adopt the projects, DHCS acknowledged that it does not formally follow up on whether the health plans do so. DHCS explained that it has considered a formal follow-up process to determine whether health plans implement successful improvement projects on a wider scale but cited various limitations, including that expanding these projects to other clinics takes significant time and could involve years of continued reporting by the health plan to DHCS.

Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality CAPs, it is missing an opportunity to ensure that health plans formally adopt successful projects and to share these with other plans.

Although we agree that type of monitoring could be extensive, we do not expect DHCS to wait years to share successful improvement projects. Instead, we believe that DHCS could compile a list of improvement projects that it determined were successful and share it with other health plans on a periodic basis. In addition, DHCS could require the health plan to annually report to it on the results of those projects the health plan intends to adopt or expand at other locations. Using this information, DHCS could identify successful improvement projects, particularly those proven effective on a wider scale, and then include these projects on the list of successful improvement projects that we describe above. DHCS agreed that adding this provision to its quality CAP process would be feasible.

DHCS Does Not Adequately Oversee Health Plans' Processes to Prevent Fraud or Conflicts of Interest

DHCS should improve its efforts to ensure that health plans have adequate processes in place to prevent or detect fraud. Federal regulations mandate that DHCS' contracts with managed care plans require the plans to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. DHCS' contracts with the plans we reviewed comply with this requirement. Each plan's fraud, waste, and abuse procedures must include establishment of a compliance committee and a system for training specified employees. Although DHCS' annual medical audits include steps for evaluating whether health plans have a fraud and abuse program that includes processes to detect and prevent fraud, we found that they did not identify shortcomings in this area for three of the nine audit reports we reviewed.

.....

Each plan's fraud, waste, and abuse procedures must include establishment of a compliance committee and a system for training specified employees.

.....

DHCS' audit procedures describe how to evaluate health plan compliance with various contract provisions, such as determining whether a health plan has policies and procedures for its fraud and abuse program, including training records and meeting minutes from its compliance committee. However, our review of nine annual medical audits of Kern, San Joaquin, and Santa Clara that DHCS issued each year from 2016 through 2018 found that DHCS consistently failed to identify a shortcoming in Kern's approach to

preventing and identifying fraud. Specifically, DHCS concluded that Kern satisfied the contract requirements related to fraud and abuse in each of its three consecutive medical audits even though the health plan never established a compliance committee as required by the contract. One intent of requiring health plans to establish a compliance committee is to ensure that the plans' processes, including their training and steps to submit and review fraud complaints, are as effective as possible at preventing and detecting fraud. Although DHCS acknowledged that its staff overlooked this shortcoming and that management should have identified it as a reportable issue during the review process, by repeatedly failing to identify this noncompliance, DHCS demonstrated that it does not consistently follow its established audit procedures.

Further, DHCS does not verify the steps health plans take to identify and prevent conflicts of interest. DHCS' contracts with the health plans we reviewed require them to adhere to specified state conflict-of-interest regulations and requirements, which include prohibiting health plans from contracting with certain individuals who have a substantial financial interest in the health plan. However, we found that DHCS does not determine through its annual medical audits whether health plans adhere to the State's conflict-of-interest requirements. To determine which contract sections to review as part of the annual medical audits, DHCS indicated that it conducted a risk assessment in 2012 and organized the contract sections it identified as high-risk areas into seven broad audit categories. It also stated that it performs annual risk assessments to include any additional areas of risk within these established audit categories. DHCS asserted that it excluded a review of a health plan's conflict-of-interest controls from these audit categories because it has not considered these controls a high-risk area. In addition, DHCS stated that it does not audit all contractual requirements each year because the scope of its annual audits is specific to the seven audit categories it established based on its 2012 risk assessment. Therefore, DHCS would not audit other contractual requirements, such as those related to conflicts of interest, unless it performed another comprehensive risk assessment and selected these requirements as part of its annual medical audits. However, DHCS indicated that it will consider updating its audit program to include conflict-of-interest controls in the future. When DHCS fails to determine whether health plans are taking steps to identify and prevent conflicts of interest, it risks that health plans are not compliant with applicable requirements and lessens assurance in a plan's ability to confirm that its staff are aware of the need to avoid contracting with providers who may have a financial interest in the plan.

Recommendations

To help identify successful improvement projects, by September 2019 DHCS should require health plans to annually report the results of those projects they plan to continue or expand to other locations. Using this information, by December 2019 DHCS should compile a list of successful improvement projects to share with other health plans on a periodic basis, but at least annually.

To ensure that DHCS consistently identifies health plans that do not have required processes to detect and prevent fraud, it should immediately reevaluate its audit program for medical audits and revise it as necessary to ensure that staff follow the audit procedures regarding fraud and abuse programs.

By September 2019, and periodically thereafter, DHCS should conduct another risk assessment and ensure that it includes a comprehensive evaluation of which contract areas—including conflicts of interest—it should focus on in its annual medical audits. Going forward, it should conduct this type of comprehensive risk assessment and ensure that it reviews health plans' conflict-of-interest controls at least once every three years.

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DHCS Does Not Ensure That Health Plans' Administrative Expenses Are Reasonable And Necessary

Key Points

- DHCS does not provide guidance on what types of administrative expenses are reasonable and necessary, which likely contributed to three health plans making some questionable administrative expenditures.
- DHCS does not oversee, or provide guidance on, health plans' bonus programs. San Joaquin and Santa Clara paid bonuses to their employees, whereas Kern did not.

DHCS Oversight of Health Plans' Administrative Expenses Is Lacking, Leading to Some Questionable Costs

DHCS' lack of guidance likely contributed to questionable administrative expenses that we identified at the three health plans we visited. Federal and state regulations generally require that health plans' administrative expenses be below 15 percent of the Medi-Cal funds they receive, and be reasonable. State regulations also require administrative expenses to be necessary. DHCS is the oversight entity to ensure compliance with applicable provisions of state and federal Medi-Cal laws. However, DHCS does not do enough to ensure, as its contracts and regulations require, that health plans' administrative expenses are reasonable and necessary. As described in the Introduction, DHCS issues guidance to health plans regarding contract and legal requirements in All-Plan Letters; however, it has not issued such guidance as it relates to reasonable and necessary administrative expenses. Further, it has not specifically defined what constitutes reasonable and necessary administrative expenses under state regulations. Without this oversight, it is not surprising that we found that Kern, San Joaquin, and Santa Clara each had some questionable administrative expenses from 2015 through 2018.

All three health plans' administrative expenses were below the 15 percent threshold, but we found that they used Medi-Cal funding for questionable purposes, including events for their employees. Both Kern and San Joaquin confirmed that they made these purchases with Medi-Cal funds. Santa Clara pays its administrative expenses from a single account using multiple revenue sources, more than 90 percent of which is Medi-Cal, with substantially all of the remainder consisting of other federal funds. Table 1 shows that, based on a selection of administrative expenses, each of the three health plans spent between \$4,600 and \$47,000 annually on expenses related to events for their employees and sometimes guests. In addition, Kern spent \$7,200 annually on an automobile allowance for its chief executive officer (CEO). Further, San Joaquin provided coffee for its employees—an expenditure approved by its board—at an annual cost of \$22,400 or more. The health plans indicated that these expenses were for increasing employee morale and retention. Although the three health plans' respective boards approve their budgets, which include total budgeted amounts for administrative expenses, the boards do not review or approve individual expenses unless they exceed certain thresholds.

Table 1
Three Health Plans Spent Thousands of Dollars on Questionable Purposes

HEALTH PLAN	ADMINISTRATIVE EXPENSE DESCRIPTION	COST	YEAR
Kern	Retirement luncheon	\$4,600	2015
	CEO annual automobile allowance	7,200	2015
	Employee recognition event	8,000	2015
	CEO annual automobile allowance	7,200	2016
	Employee and family event at county fair	6,300	2016
	Employee recognition event	11,200	2016
	CEO annual automobile allowance	7,200	2017
	Employee recognition event	23,400	2017
	CEO annual automobile allowance	7,200	2018
	Employee recognition event	47,000	2018
Total		\$129,300	
San Joaquin	Employee celebration	\$12,800	2015
	Employee coffee	22,400	2015
	Employee coffee	28,200	2016
	Employee coffee	27,300	2017
	Employee end of year party	10,000	2017
	Employee coffee	25,400	2018
Total		\$126,100	
Santa Clara	Employee picnic	\$5,000	2016
	Employee picnic	10,500	2017
	Employee picnic	7,000	2018
Total		\$22,500	
	Total of All Three Health Plans		\$277,900

Source: Analysis of a selection of the three health plans' administrative expenses from 2015 through 2018.

We question how DHCS would consider these expenses reasonable. Further, these expenses are not strictly necessary for the health plans to operate. DHCS explained that it oversees health plans' administrative expenses at the aggregate level—meaning that it performs a calculation to ensure that each health plan's administrative expenses do not exceed 15 percent of its net revenue. DHCS stated that it does not perform audits of health plans' financial information and that it monitors the health plans' aggregate expenditures at the category level, such as the total amount they spend on marketing. However, we believe this limited review is insufficient because as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that the health plans comply with contractual and legal requirements that administrative expenses be reasonable and necessary.

State law and regulations are, in some instances, inconsistent. For example, one section of state regulations generally authorizes charitable or other contributions as allowable administrative expenses, while another section specifically prohibits donations as allowable administrative expenses. Further, state regulations generally define allowable administrative expenses in broad categories, such as the cost of soliciting and enrolling subscribers and enrollees; salaries, bonuses, and benefits; costs associated with the establishment and maintenance of provider agreements; and the costs of marketing. Conversely, federal regulations specifically disallow spending federal funds for entertainment costs. DHCS asserted, however, that these specific federal regulations are not applicable to the health plans because they receive premiums to provide managed care instead of a fee-for-service reimbursement.

Without specific guidance and direct oversight from DHCS, the health plans indicated that they rely on existing requirements and their own professional judgment to determine what administrative expenses are reasonable and necessary, which likely contributed to them making the questionable expenditures we show in Table 1. Thus, DHCS risks that health plans are making administrative expenses that are not reasonable and necessary. Therefore, we believe that DHCS would benefit from providing specific direction to the health plans regarding the types of administrative expenses that are reasonable and necessary.

The Health Plans' Bonus Programs Vary, and DHCS Lacks Guidance on What Constitutes Reasonable Bonuses

State and federal regulations both allow health plans to use Medi-Cal funding to pay employees reasonable bonuses. However, we found that the three health plans we reviewed take different approaches when determining executive and staff bonuses, resulting in amounts that vary widely from one plan to another. Likely contributing to these inconsistencies is that DHCS does not oversee health plans' employee bonuses. Specifically, DHCS does not provide guidance to health plans on the types of bonus programs that are reasonable. As state law designates DHCS as the oversight entity to ensure full compliance with both its Medi-Cal contracts and applicable provisions of state and federal law, DHCS is responsible for ensuring that the health plans it contracts with and oversees have reasonable and necessary administrative expenses, including bonuses.

San Joaquin and Santa Clara both spent Medi-Cal funds on employee bonuses, whereas Kern did not pay bonuses to employees. Table 2 shows a comparison of the total bonus

amounts San Joaquin and Santa Clara paid to their executives and other employees from fiscal years 2015–16 through 2017–18. San Joaquin stated that it believes the bonuses it paid its executives and certain other employees are reasonable because its governing board approved them and because it competes against commercial health plans, so its compensation must therefore be competitive to attract and retain talented employees. In contrast, Kern explained that it maintains and administers a compensation program based on employee performance that does not currently include bonuses for any of its employees.

Table 2
San Joaquin Paid Higher Bonuses Than Santa Clara From Fiscal Years 2015–16 Through 2017–18

	SAN JOAQUIN			SANTA CLARA		
	AMOUNT	EMPLOYEES THAT RECEIVED BONUSES	AVERAGE BONUS PER EMPLOYEE	AMOUNT	EMPLOYEES THAT RECEIVED BONUSES	AVERAGE BONUS PER EMPLOYEE
Fiscal Year 2015–16						
Executives	\$144,200	7	\$20,600	\$46,200	5	\$9,200
Other Employees	358,100	44	8,100	286,100	145	2,000
Totals	\$502,300	51	–	\$332,300	150	–
Fiscal Year 2016–17						
Executives	\$337,100*	7	\$48,200	\$59,700	5	\$11,900
Other Employees	437,900	48	9,100	280,200	188	1,500
Totals	\$775,000	55	–	\$339,900	193	–
Fiscal Year 2017–18						
Executives	\$220,000*	5	\$44,000	\$30,300 [†]	1	\$30,300
Other Employees	434,200	54	8,000	0	0	0
Totals	\$654,200	59	–	\$30,300	1	–

Source: San Joaquin's and Santa Clara's reported bonus payments to executives and other employees.

Note: San Joaquin stated that it did not award bonuses to two executives for fiscal year 2017–18.

* The amounts for San Joaquin's executives in fiscal years 2016–17 and 2017–18 include deferred compensation, which the health plan stated consists of funds it places into an account that is an asset of the health plan until the employees withdraw it.

[†] Santa Clara stated that it did not meet the goals of its bonus program and decided not to pay bonuses to any of its employees in fiscal year 2017–18, with the exception of its CEO.

We found that San Joaquin and Santa Clara followed their policies when awarding bonuses. San Joaquin and Santa Clara both have high-level policies stating that they will generally base the amounts of employee bonuses on position, salary, and performance in achieving bonus program objectives. For example, based on employee position and their annual base salary, in fiscal year 2017–18 San Joaquin allowed for up to an 18 percent bonus for the CEO and up to 15 percent for other executives. Ultimately, San Joaquin paid its executives bonuses of roughly

10 percent of their base salaries in fiscal year 2017–18. In addition, the health plan paid its CEO a bonus of 12 percent of her base salary for fiscal year 2017–18, and a bonus of 14 percent of her base salary in fiscal year 2016–17. San Joaquin stated that it uses compensation studies to inform the amounts it pays under its bonus program, along with its need to attract and retain highly qualified employees. Santa Clara’s policy allows for a maximum of 5 percent of employees’ base salaries as bonuses, with the exception of the CEO, who may receive a larger bonus. For example, in fiscal year 2016–17 the health plan paid bonuses of 2 percent of employees’ annual salaries, and it did not pay bonuses to employees in fiscal year 2017–18 because the plan did not meet its bonus program objectives. On the other hand, Santa Clara’s CEO received a bonus of 7 percent in fiscal year 2017–18 because the health plan’s governing board determines the CEO bonus each year based on her employee contract, her individual performance, and other factors. Santa Clara stated that it based its rationale for determining whether these percentages were reasonable upon a comparison to other health plans, and the CEO’s previous experience in working at other health plans. Finally, we found that both health plans considered whether they met their bonus program objectives when determining the bonus amounts they paid during the period we reviewed.

DHCS does not believe its role is to provide guidance regarding what constitutes a reasonable bonus program. However, we found that the health plans’ bonus programs we reviewed varied and in some cases were questionable. For instance, San Joaquin paid its employees bonuses during years when it was performing poorly and was on a quality CAP. Further, we found that despite comparable executive salaries, San Joaquin paid its executives higher bonuses than those paid by Santa Clara. Without providing guidance, DHCS risks that health plans will pay bonuses when they are performing poorly, or will pay bonuses that are excessive.

Recommendations

DHCS should develop and issue an All-Plan letter or other binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses. Further, it should provide guidance to health plans on what is a reasonable bonus program. In doing so, DHCS should perform the necessary oversight to ensure health plans comply with this direction.

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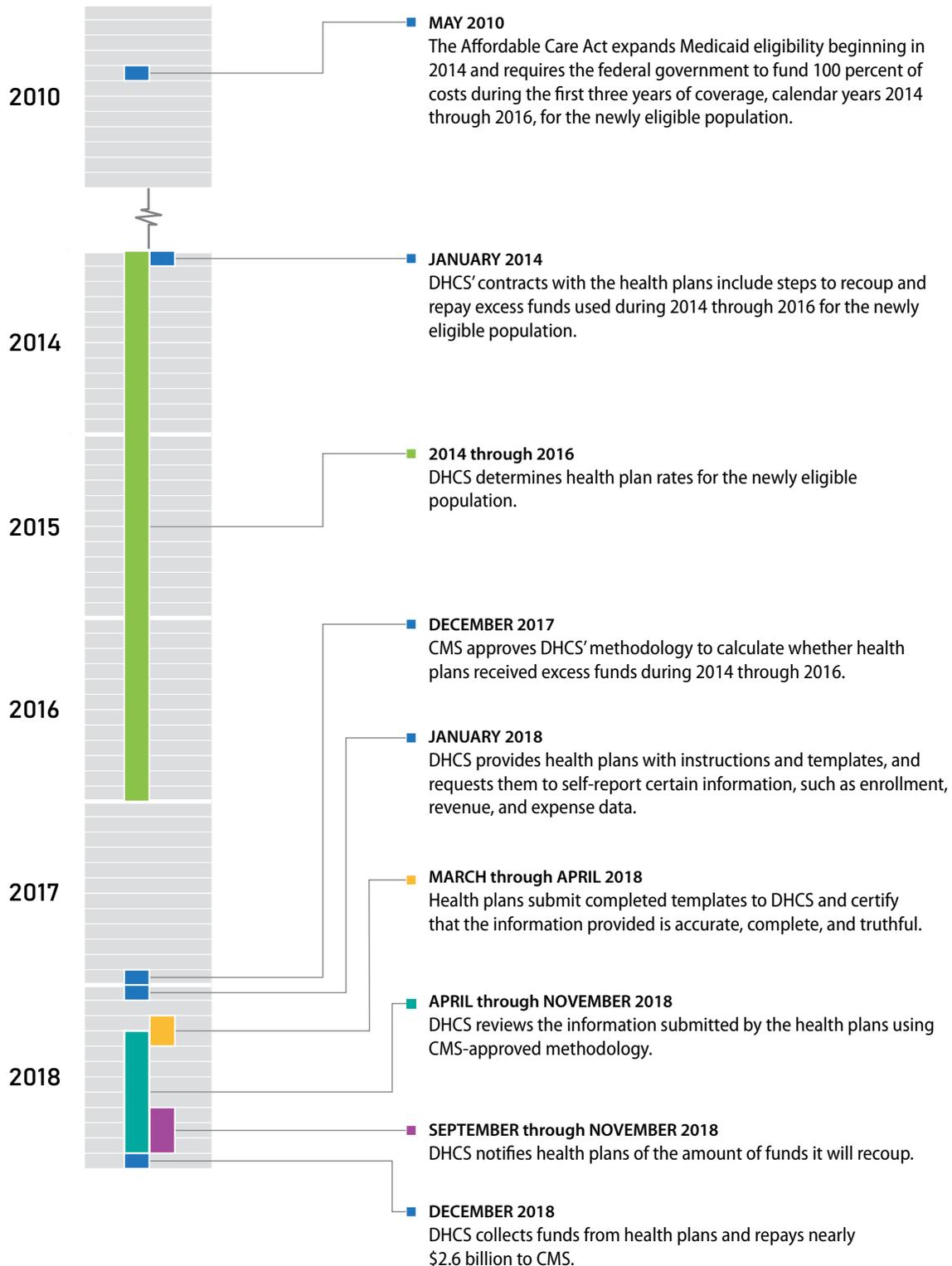
DHCS Properly Recouped Excess Funds From Health Plans

Key Point

- DHCS recovered nearly \$2.6 billion in excess payments to health plans resulting from implementation of the federal Patient Protection and Affordable Care Act (Affordable Care Act).

DHCS complied with federal requirements in recouping excess funds it paid to health plans during the first three years of expanded coverage resulting from the Affordable Care Act. The Affordable Care Act expanded Medicaid eligibility requirements for certain adults in participating states and required the federal government to fund 100 percent of the health care costs for this population during the first three years of expanded coverage—2014 through 2016. In 2013 state law was amended to expand Medicaid eligibility in California. Subsequently, DHCS included provisions in its Medicaid contracts with the health plans requiring DHCS to calculate and repay the federal government any excess funds they received from covering this newly eligible population. Specifically, DHCS amended the contracts to require the health plans to spend at least 85 percent of the premiums, less certain designated amounts, they received on allowed medical expenses for newly eligible beneficiaries. Health plans that spent less than 85 percent are required to repay the difference. Alternately, health plans that spent more than 95 percent on allowed medical expenses are reimbursed by DHCS, while health plans that spent between 85 and 95 percent on allowed medical expenses do not pay or receive any funds. Figure 6 on the following page shows the timeline DHCS followed to recoup the excess funds health plans received from covering the expanded adult Medi-Cal population and to repay the federal government.

In December 2017, CMS—the federal agency that oversees the Medicaid program—approved DHCS' proposed methodology to calculate whether health plans received excess funds and to recoup these funds if necessary. This methodology included steps to review each health plan's self-reported data and compare them to data the health plans previously reported to better assess accuracy, completeness, and reasonableness, and make any adjustments it deemed necessary. DHCS completed the recoupment process in December 2018 and repaid CMS nearly \$2.6 billion in excess funds, as Table 3 shows on page 33. Although DHCS acknowledged that it did not audit the health plans' self-reported data before approving the recoupment amounts, the CMS-approved methodology includes provisions for DHCS, CMS, and other state or federal oversight entities to reserve the right to audit health plans' data in the future. In addition, CMS notified DHCS that it engaged a contractor to conduct audits that will be initiated in 2019 and include a review of the health plans' self-reported data to ensure that the total recouped amount is accurate.

Figure 6**DHCS Recouped and Repaid CMS Nearly \$2.6 Billion to Cover Excess Funds Paid to Health Plans**

Source: The Affordable Care Act, DHCS' methodology—approved by CMS—used to calculate the amount of excess funds health plans had to remit to DHCS, and DHCS' timeline to complete the recoupment process.

Our examination of DHCS' process to review the health plans' self-reported data found that it consistently adhered to procedures that are described in CMS' approved calculation methodology that required DHCS to compare a health plan's reported enrollment, revenue, and expense data to corresponding data in DHCS' systems. To ensure that it complied with the approved methodology, DHCS developed roughly 70 procedural steps to review the health plans' self-reported data. DHCS' procedures include steps such as analyzing health plans' reported expenses and completing a qualitative review of a selection of incentive payments, which are made by health plans to providers to promote or reward improved quality of care. We reviewed selected elements of DHCS' review of Kern's reported data and found that DHCS sufficiently followed and documented the proper steps.

Table 3
DHCS Recouped Excess Funds From the Health Plans Ranging From \$3 Million to \$316 Million to Repay CMS

HEALTH PLAN	TOTAL EXCESS FUNDS RECOUPED (IN MILLIONS)
Alameda Alliance for Health	\$179.3
Anthem Blue Cross Partnership Plan	184.2
California Health & Wellness	99.7
CalOptima	101.8
CalViva Health*	0
Care 1st Partner Plan, LLC	88.9
CenCal Health	83.9
Central California Alliance for Health	286.1
Community Health Group Partnership Plan	121.5
Contra Costa Health Plan*	0
Gold Coast Health Plan	160.5
Health Net Community Solutions, Inc.	272.1
Health Plan of San Joaquin	143.4
Health Plan of San Mateo	109.3
Inland Empire Health Plan	33.0
Kaiser Permanente	33.4
Kern Health Systems	21.8
Los Angeles Care Health Plan	226.2
Molina Healthcare of California Partner Plan, Inc.	92.1
Partnership Health Plan of California	316.4
San Francisco Health Plan	6.7
Santa Clara Family Health Plan	3.0
Total	\$2,563.3

Source: DHCS notification letters to health plans regarding the amount of excess funds that it would recoup.

Note: The Aetna Better Health of California, Rady Children's Hospital, and the United Healthcare Community Plan are excluded from this table because these plans did not begin contracting with DHCS until after the Affordable Care Act expansion.

* CalViva Health and the Contra Costa Health Plan did not owe DHCS funds because these plans spent more than 85 percent of their premiums, less certain designated amounts, on allowable expenses for newly eligible beneficiaries.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Date: April 4, 2019

APPENDIX

Scope and Methodology

The Audit Committee directed the California State Auditor to examine DHCS' oversight of San Joaquin and similar health plans. Specifically, it directed us to identify the actions DHCS has taken to ensure that health plans provide quality of care that meets key state and federal standards. It also directed us to determine whether DHCS provides sufficient oversight of health plans' administrative expenses and employee bonuses. The table below lists the objectives that the Audit Committee approved and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant laws and regulations related to DHCS' oversight responsibilities for health plans.
2 Determine whether DHCS has conducted all required audits and rate adjustments of health plans, and evaluate its effectiveness in adjusting rates.	<ul style="list-style-type: none"> • Determined that DHCS' required annual medical audits do not affect health plan rate adjustments. Therefore, we interviewed DHCS staff and reviewed relevant federal laws and documents to determine what type of payment adjustments DHCS is responsible for making. • Evaluated DHCS' effectiveness and timeliness in recouping excess funds it provided to the health plans resulting from implementation of the Affordable Care Act and repaying them to CMS. • Reviewed DHCS' calculations for one health plan's total recoupment amount to ensure that it adhered to CMS' approved calculation methodology.
3 Identify and evaluate the results of actions taken by DHCS in the most recent two or three years to improve the quality of health care services delivered by San Joaquin and similar health plans, including any changes to Medi-Cal payments.	<ul style="list-style-type: none"> • Identified health plans DHCS considered to be similar to San Joaquin. Selected three similar health plans—Anthem, Health Net, and Molina—in addition to San Joaquin that were on quality CAPs between 2014 and 2017. We identified actions taken by DHCS to improve the quality of health care services delivered by these health plans. • Interviewed DHCS staff to determine whether it lowers Medi-Cal payments to health plans to improve health care quality. DHCS stated that it could not lower health plan payments due to poor performance because the rates it pays health plans are already as low as the law allows. • Using relevant data on health plans' performance in meeting or exceeding the MPLs for DHCS' established quality indicators, evaluated the performance trends of the health plans between 2013 and 2017 overall and specifically in the areas of diabetes, postpartum care, and monitoring persistent medications to assess the results of DHCS' actions to improve quality.
4 Identify steps DHCS has taken to ensure that the quality of care by San Joaquin and similar health plans meets key state and federal standards, including, but not limited to, standards in the area of postpartum care and diabetes treatments.	<ul style="list-style-type: none"> • Evaluated the actions DHCS took between 2013 and 2017 to ensure that the four health plans that were on quality CAPs met key state and federal quality of care requirements. • For example, for these four health plans, we assessed DHCS' adherence to its policies and procedures for its two primary oversight methods—quality CAPs and audit CAPs—to help ensure that health plans' quality of care meets key state and federal requirements.

continued on next page . . .

AUDIT OBJECTIVE	METHOD
5 Determine whether DHCS provides sufficient management and oversight of San Joaquin and similar health plans, including, but not limited to, oversight of administrative costs and bonuses paid to employees.	Interviewed DHCS staff to determine whether it evaluates health plans' administrative expenses and employee bonuses to ensure that they are reasonable and necessary. Also, we determined whether DHCS provides guidance to health plans regarding what administrative expenses are reasonable and necessary.
6 Evaluate whether DHCS' oversight ensures that San Joaquin and similar health plans have sufficient controls in place to detect and prevent waste, abuse, mismanagement, and conflicts of interest.	<ul style="list-style-type: none"> • Reviewed DHCS' contracts with health plans to assess whether they require health plans to implement processes to detect and prevent waste, abuse, mismanagement, and conflicts of interest. • Interviewed DHCS staff and reviewed its annual medical audit policies and procedures to assess whether DHCS oversees health plans' processes to prevent and detect waste, abuse, mismanagement, and conflicts of interest. Reviewed the annual medical audits DHCS completed of Kern, San Joaquin, and Santa Clara between 2016 and 2018 to determine whether DHCS sufficiently evaluated whether the health plans had processes in place to prevent fraud, waste, and abuse.
7 To the extent possible, determine whether DHCS' administrative costs, including its employee bonuses, are appropriate and allowable under Medi-Cal funding conditions.	<ul style="list-style-type: none"> • For San Joaquin and two similar health plans we reviewed that were not on quality CAPs—Kern and Santa Clara—we used their financial information to determine whether their total administrative expenses were within 15 percent of the total Medi-Cal funds they received as state regulations generally require. Further, we reviewed a selection of administrative expenses the health plans made from 2015 through 2018 to identify whether they were reasonable and necessary. We also reviewed their bonus programs to determine whether they were reasonable and whether the health plans paid bonuses in compliance with their policies. • For a judgmental selection of 20 contracts, we reviewed documentation to determine whether San Joaquin followed its contracting policies. We did not identify any reportable issues.
8 Review and assess any other issues that are significant to the audit.	We did not identify any other significant issues.

Source: Analysis of the Audit Committee's audit request number 2018-115, as well as information and documentation identified in the column titled Method.

April 2019



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides responses to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*. The CSA conducted this audit and issued five findings and four recommendations.

DHCS agrees with three recommendations and partially agrees with one recommendation, and has prepared corrective action plans to implement them. DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Coordination Manager, at (916) 713-8812.

Sincerely,



Jennifer Kent
Director

Enclosure

Director's Office
Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413, Sacramento, CA 95899-7413
(916) 440-7400 / (916) 440-7404 FAX
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* California State Auditor's comments begin on page 47.

Ms. Elaine M. Howle
Page 2

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The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

Finding 1: Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality Corrective Action Plans (CAP), it is missing an opportunity to ensure that health plans formally adopt successful projects and to identify best practices that can be shared with other plans. Specifically, once an improvement project reaches its completion, the health plan can choose to adopt or abandon the project. If a health plan chooses to adopt the improvement project, it may do so at only the location where it was completed or it may expand the project to other locations. In instances in which the improvement projects are successful and the health plan indicates it will adopt, DHCS acknowledged that it does not formally follow up on whether the health plans do so.

Finding Agreement: Fully Agrees with Finding

Recommendation 1: To help identify best practices from successful improvement projects, by September 2019, DHCS should require health plans to annually report the results of those projects they plan to continue or expand to other locations. Using this information, by December 2019, DHCS should compile a list of successful improvement projects to share with other health plans on a periodic basis, but at least annually.

Recommendation Agreement: Fully Agrees with Recommendation

Response: DHCS currently compiles information from Medi-Cal managed care health plan (MCP) Plan Do Study Act (PDSA) cycles, Performance Improvement Projects, and CAP submissions to track the types of interventions that MCPs are exploring. DHCS shares promising practices as well as lessons learned based on this information with MCPs through individual MCP technical assistance calls, Quality Collaborative Teleconferences attended by all MCPs, Quality Improvement Highlights that are sent to all MCPs, and a variety of in person meetings, including the quarterly Medical Directors Meetings.

DHCS also has developed a Quality Improvement Toolkit that allows MCPs to access many applicable resources in one location through an external SharePoint site.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

DHCS will engage further with MCPs to share promising practices and issue a document summarizing those promising practices, including results of successful PDSA cycles that the MCPs plan to expand. DHCS will work with MCPs to identify appropriate promising or best practices to be implemented in their respective geographic areas.

In addition, DHCS will require MCPs to annually report the results of successful improvement projects they plan to continue or expand to other locations, including whether or not prior year efforts were adopted.

- Implementation Status:** Fully Implemented:
 Implementation Date:
- Not Fully Implemented:
 Estimated Implementation Date: December 1, 2019
- Will Not Implement
- Substantiation:** Attached (Fully Implemented)
- Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 2: DHCS should improve its efforts to ensure health plans have adequate processes in place to prevent or detect fraud. Federal regulations mandate that DHCS' contracts with managed care plans require the plans to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse.

Although DHCS' annual medical audits include steps for evaluating whether health plans have a fraud and abuse program that includes processes to detect and prevent fraud, they did not identify shortcomings in this area for three of the nine audit reports reviewed.

Finding Agreement: Fully Agrees with Finding

Recommendation 2: To ensure DHCS consistently identifies health plans that do not have required processes to detect and prevent fraud, it should immediately reevaluate its audit program for medical

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary* Report Number: 2018-115 (18-15)

audits and revise it as necessary to ensure that staff follow the audit procedures concerning fraud and abuse programs.

Recommendation Agreement:

Fully Agrees with Recommendation

Response:

DHCS accepts this finding with respect to Kern. DHCS plans to perform an internal review of audit work papers to identify the extent of this issue. DHCS also plans to follow up with staff to identify gaps in internal controls surrounding our audit procedures.

Additionally, DHCS is reevaluating our medical audit review process and looking for ways to implement controls to ensure that staff follow annual medical audit procedures.

Implementation Status:

- Fully Implemented:
Implementation Date:
- Not Fully Implemented:
Estimated Implementation Date: July 1, 2019
- Will Not Implement

Substantiation:

- Attached (Fully Implemented)
- Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 3:

DHCS does not verify the steps health plans take to identify and prevent conflicts of interest. DHCS' contracts with the health plans we reviewed require them to adhere to specified state conflict of interest regulations and requirements, which include prohibiting health plans from contracting with certain individuals who have a substantial financial interest in the health plan. However, we found that DHCS does not determine through its annual medical audits whether health plans adhere to the state's conflict of interest requirements. When DHCS fails to determine whether health plans are taking steps to identify and prevent conflicts of interest, it risks that health plans are not compliant with applicable requirements and lessens assurance in a plan's ability to confirm that its staff is aware of the need to avoid contracting with providers who may have a financial interest in the plan.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

Finding Agreement: Fully Agrees with Finding

Recommendation 3: By September 2019 and periodically thereafter, DHCS should conduct another risk assessment and ensure that it includes a comprehensive evaluation of which contract areas—including conflicts of interest—it should focus on in its annual medical audits. Going forward, it should conduct this type of comprehensive risk assessment and ensure that it reviews health plans' conflicts of interest controls at least once every three years.

Recommendation Agreement: Fully Agrees with Recommendation

Response: The scope of DHCS' annual medical audits is risk based and, to date, conflict of interest controls and procedures have not been considered a high risk area. In light of the recommendation, DHCS plans to develop additional audit steps to review each plan's conflict of interest process. Specifically DHCS will draft audit procedures to verify the steps taken by the plans to prevent conflict of interest and determine whether they adhere to the state's requirements. DHCS will also look at the plan's processes and controls.

DHCS' annual audit scoping for each year's medical audits includes a reassessment of each respective plan's associated risks. The scope of the audit is then augmented, or modified, to include audit test work in the areas that warrant the most attention. DHCS will revisit our processes to evaluate risks during both the annual audit planning/scoping and the assessment of global risk categories to ensure our evaluation of risks are comprehensive.

Implementation Status: Fully Implemented:
 Implementation Date:
 Not Fully Implemented:
 Estimated Implementation Date: September 1, 2019
 Will Not Implement

Substantiation: Attached (Fully Implemented)

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary* Report Number: 2018-115 (18-15)

Not Applicable (Not Fully Implemented or Will Not Implement)

- Finding 4:** Federal and state regulations generally require that health plans' administrative expenses be below 15 percent of their revenue, and be reasonable. State regulations also require administrative expenses to be necessary. DHCS is the oversight entity to ensure compliance with applicable provisions of state and federal Medi-Cal laws. However, DHCS does not do enough to ensure, as its contracts and regulations require, that health plans' administrative expenses are reasonable and necessary. DHCS issues guidance to health plans regarding contract and legal requirements in All-Plan Letters; however, it has not issues such guidance as it relates to reasonable and necessary administrative expenses. Further, it has not specifically defined what constitutes reasonable and necessary administrative expenses under state regulations.
- Finding Agreement:** Partially Agrees with Finding
- Finding 5:** State and federal regulations both allow health plans to use Medi-Cal funding to pay employees reasonable bonuses. However, we found that the three health plans we reviewed take different approaches when determining executive and staff bonuses, resulting in amounts that vary widely from one plan to another. Likely contributing to these inconsistencies is that DHCS does not oversee health plans' employee bonuses. Specifically DHCS does not provide guidance to health plans on the types of bonus programs that are reasonable. As state law designates DHCS as the oversight entity to ensure full compliance with both its Medi-Cal contracts and applicable provisions of state and federal law, DHCS is responsible for ensuring the health plans it contracts with and oversees have reasonable and necessary administrative costs, including bonuses.
- Finding Agreement:** Disagrees with Finding
- Recommendation 4:** DHCS should develop and issue an All-Plan letter or other binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary* Report Number: 2018-115 (18-15)

necessary administrative expenses. Further, it should provide guidance to health plans on what is a reasonable bonus program. In doing so, DHCS should perform the necessary oversight to ensure health plans comply with this direction.

Recommendation Agreement:

Partially Agrees with Recommendation

Response:

DHCS supports the prudent use of federal and state Medicaid resources. DHCS is prohibited by federal law from directing a plan's administrative expenditures, absent express approval which is not available in this context. Therefore, DHCS fundamentally disagrees with the underlying assumptions of the findings and recommendation, and views them to be based on a flawed interpretation of applicable federal law and a misunderstanding of DHCS's rate setting practices related to administration. DHCS sees potential value in issuing clarifying guidance to plans, as DHCS deems appropriate, on the types of administrative costs that may be reported for purposes of rate development.

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Regarding reasonable and necessary costs, DHCS maintains that its oversight of plans is based in, and limited by, its contracts with plans and its role as the Medicaid Agency, which does not confer sweeping regulator-like authority to direct or limit how a plan spends capitation payments received from DHCS for administration. It is important to note that DHCS does not reimburse plans for their actual incurred administrative costs, and does not formulaically base a plan's premiums on that plan's reported administrative costs. Instead, when developing the administrative portion of a plan's premiums, DHCS's actuaries annually evaluate plan reported administrative costs to determine reasonable and appropriate levels of funding to include in the final premiums. This rate-setting control incentivizes administrative efficiency as plans' administrative costs are not reimbursed on a one-to-one basis. In addition, federal actuaries annually review and approve the developed premiums, and this mechanism has been demonstrated to be successful as all plans are operating beneath the "reasonable and necessary" 15 percent administrative cost threshold outlined in DHCS-plan contracts and applicable federal and State Medicaid law.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary* Report Number: 2018-115 (18-15)

DHCS disagrees with the recommendation to issue guidance specific to plan bonus programs. Due to the diversity of possible compensation arrangements, it would be ineffective to issue guidance on bonus programs without also issuing guidance on other methods of compensation (such as salaries). DHCS believes a single, one-size-fits-all policy regarding reasonable and necessary compensation and bonuses is inherently difficult, if not impossible, to fashion based on the significant differences in local markets faced by plans and structural differences across Medi-Cal plans, which include County Organized Health Systems, Local Initiative plans, and publicly traded commercial plans. Further, pursuant to federal law, DHCS would not have the authority to enforce this guidance. Transparency of CEO compensation and bonuses for locally-governed Medi-Cal plans is publicly available and allows for each board to make determinations for appropriate compensation in a way that balances stewardship of public dollars with ability to attract qualified executives.

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- Implementation Status:** Fully Implemented:
Implementation Date:
- Not Fully Implemented:
Estimated Implementation Date: March 2020
- Will Not Implement
- Substantiation:** Attached (Fully Implemented)
- Not Applicable (Not Fully Implemented or Will Not Implement)

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COMMENTS

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on DHCS' response to the audit. The numbers below correspond to the numbers we have placed in the margin of DHCS' response.

We disagree that our finding and recommendation is based on a flawed interpretation of federal law and that federal law prohibits DHCS from directing a plan's administrative expenditures. As we describe on page 25, federal regulations, as well as state law and DHCS' contracts with the health plans, require administrative expenses to be reasonable. State regulations also require that they be necessary. Moreover, as we state on page 26, as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that the health plans comply with contractual and legal requirements for administrative expenses to be reasonable and necessary. Thus, we stand by our recommendation that DHCS develop and issue an All-Plan letter or binding guidance to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses, and perform the necessary oversight to ensure they comply with this direction.

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DHCS misunderstands the basis of our finding. Specifically, our finding is not based on DHCS' rate setting practices, including how it develops health plans' premiums. Regardless of its rate setting practices, DHCS still has an obligation to ensure health plans' administrative expenses are reasonable and necessary. As we state on page 26, as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that health plans comply with contractual and legal requirements that administrative expenses be reasonable and necessary. Thus, until it develops and issues guidance to the health plans on what constitutes reasonable and necessary administrative expenses, as we recommend on page 29, DHCS risks that health plans will make questionable administrative expenditures.

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We disagree that federal regulations, state law, or DHCS' contracts with the health plans define "reasonable and necessary" administrative expenses as a 15 percent threshold, as DHCS indicates in its response. As we state on page 25, health plans' administrative expenses cannot exceed 15 percent of their revenue and must be reasonable and necessary. Moreover, there is nothing precluding DHCS from requiring stricter standards, such as lowering the threshold, with CMS approval. In fact, our recommendation on page 29 intends

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to ensure that DHCS provides health plans with direction on what administrative expenses constitute reasonable and necessary, rather than relying on only the 15 percent threshold.

- ④ DHCS misunderstands our recommendation that it issue guidance to health plans regarding what constitutes a reasonable bonus program. We do not recommend that DHCS provide a one-size-fits-all policy. As we describe on page 27, state and federal regulations require that bonus programs be reasonable, and DHCS performs no oversight of health plans' bonus programs. This lack of oversight, as we state on pages 27 to 29, likely contributed to two of the health plans taking different approaches when determining executive and staff bonuses, and the third health plan not having a bonus program, resulting in amounts that vary widely from one plan to another. Notably, one of the three health plans we reviewed awarded bonuses to its employees and executives when it was performing poorly and while on a quality CAP. In fact, this health plan decided in January 2019 to provide its chief executive officer with a bonus of more than \$50,000 even though DHCS had imposed a monetary sanction of \$135,000 on it in October 2018 for not meeting the quality CAP requirements. In this instance, the absence of DHCS guidance allowed a health plan to award its CEO a bonus even though the health plan, under her leadership, was failing to meet the quality of care standards for its beneficiaries. Therefore, we stand by our recommendation.

April 2019



March 1, 2019

Ms. Elaine Howle, CPA
California State Auditor
621 Capital Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

We thank the California State Auditor for this opportunity to clarify certain comments regarding Santa Clara Family Health Plan (the Plan).

Funding Usage

The Plan receives funding from a variety of sources, including federal, state and county government funds plus investment and rental income. The Plan uses funding from all sources to pay its medical and administrative expenses. The health plan uses its professional judgment and experience prior to incurring administrative expenses, all of which were considered reasonable, necessary and in compliance with current regulatory requirements. ①

Annual Company Picnics

On an annual basis, the Plan sponsors an employee picnic. These are very modest events with an average cost of under \$30 per person. Attendance of all employees is encouraged, no alcohol is allowed, and non-employees do not attend. The purpose of these picnics is to enhance employee morale, build teamwork and increase employee retention - all of which are necessary to retain talented employees in the Silicon Valley area. We are unaware of any state or federal regulations precluding holding employee picnics. ①

Team Incentive Program

The Plan maintains a program for all employees (other than the Plan's CEO) to earn a Team Incentive of up to 5% of base salary. To qualify for any payment, the Plan must achieve a net operating surplus and achieve certain annually-determined team incentive goals. The team incentive goals are a subset of the Plan's annual goals. The Governing Board reviews plan performance at fiscal year-end and approves any team incentive payout.

CEO Incentive Bonus

As per the CEO's employment agreement, the CEO is eligible for an annual incentive bonus. The amount of the bonus is determined by the Plan's Governing Board based on the CEO's job performance which is largely contingent on attaining the Plan's annual goals.

Sincerely,

A handwritten signature in cursive script that reads "Christine M. Tomcala".

Christine M. Tomcala
Chief Executive Officer

PO Box 18880, San Jose, CA 95158
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COMMENT

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM SANTA CLARA FAMILY HEALTH PLAN

To provide clarity and perspective, we are commenting on Santa Clara Family Health Plan's (Santa Clara) response to the audit. The number below corresponds to the number we have placed in the margin of Santa Clara's response.

We disagree with Santa Clara that its administrative expenses were reasonable, necessary, and in compliance with regulatory requirements. As we state on page 25, federal and state regulations generally require health plans' administrative expenses to be reasonable, and state regulations also require administrative expenses to be necessary. Table 1 on page 26 shows that we identified more than \$22,000 in questionable administrative expenses that Santa Clara spent on employee picnics. As we state on page 27, federal regulations specifically disallow spending federal funds for entertainment costs. Further, although Santa Clara correctly states that it has multiple funding sources, as we describe on page 25, more than 90 percent of this funding is Medi-Cal, with substantially all of the remainder consisting of other federal funds. Therefore, we stand by our conclusions.

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