COMMITMENT
INTEGRITY
LEADERSHIP

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FACT SHEET

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Department of Health Care Services

It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care

Background

Overseen by the Department of Health Care Services (DHCS), the California Medi-Cal Assistance Program (Medi-Cal) provides public health insurance to certain low-income individuals and families who meet federal and state eligibility requirements. Nearly 13 million Medi-Cal beneficiaries receive their health care through one of two delivery systems: fee-for-service and managed care. Under fee-for-service, medical providers bill DHCS directly for approved services they provide to beneficiaries, while under the managed care model, DHCS contracts with health plans and pays each a monthly capitation payment per beneficiary to provide health care. In 2012 state law required DHCS to transition 28 fee-for-service counties in rural areas to managed care—eight counties joined a health plan called Partnership Health Plan of California, while DHCS worked with two other counties to create their own managed care models. DHCS grouped the 18 remaining counties into a new managed care model called the Regional Model. DHCS contracted with two commercial health plans to deliver managed care services in the Regional Model and established the requirements for adequate access to care and quality of care that these health plans must meet.

Key Recommendations

- DHCS should develop written guidance and establish criteria for processing requests for exceptions to access requirements, including processes for ensuring that health plans are making reasonable efforts to meet these requirements. It should require the health plans to authorize out-of-network care if they do not demonstrate those efforts.
- DHCS should ensure that beneficiaries in the Regional Model counties have reasonable access to care by determining why certain health plans are unable to provide such access, evaluating structural characteristics of managed care models that would be better suited to providing reasonable access, and notifying the counties of its conclusions. If counties desire to transition to another model, DHCS should assist them in making that charge after their current contracts expire.

Key Findings

- DHCS did not hold the Regional Model health plans accountable to providing beneficiaries with adequate access to care.
  - » It approved exceptions to the access requirements that health plans requested even though it had not ensured that the health plans had exhausted all other reasonable options to identify providers that would meet those requirements.
  - » Some beneficiaries had to travel hundreds of miles to receive medical care from providers, even though care was available from closer providers who contracted with other health plans.
- DHCS has not adequately engaged with the Regional Model counties over the past seven years regarding their managed care model and contracted health plans.
  - » It did not actively educate the counties about the managed care options available to them.
  - » It did not seek feedback from Regional Model counties regarding their satisfaction with a health plan before extending its contract with that health plan.

An Example of Beneficiaries in the Same Location Traveling Significantly Different Distances to Receive the Same Services