



HFMA Annual Legislative and Regulatory
Update Conference
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**Department of Managed Health Care
Office of Provider Oversight
Overview & Update**

Lora Gilmore, Acting Asst. Deputy Director



The OPO's Primary Role

- Ensuring medical group solvency
- Assisting providers in recovering unpaid/underpaid/late paid claims
- Protecting enrollees' access to networks of care





Welcome to California

The OPO: History

Key Milestones – Establishing provider solvency/provider complaint functions

1999:

SB 260 (Chapter 529, Statutes of 1999)

2000:

AB 1455 (Chapter 827, Statutes of 2000)



The OPO: History

SB 260 (Chapter 529, Statutes of 1999)

- § 1375.4
- Defines “risk-bearing organization” (RBO)
 - Generally, RBOs are medical groups that pay claims and have been delegated risk from health plans
- Places certain financial standards on RBOs
- Requires the DMHC’s Director to adopt regulations establishing “a process for reviewing or grading RBOs based on specified criteria”





The OPO: History

SB 260 Regulations

- §§ 1300.75.4 through 1300.75.4.8
- “Grading/solvency criteria” for RBOs
- Requires RBOs to meet a cash-to-claims ratio
 - Measurement of the cash and readily available receivables in comparison to the RBOs’ medical claims liability
 - Early warning signal of possible financial difficulties
- Requires RBOs to submit quarterly & annual submissions regarding compliance with the grading/solvency criteria
- Requires RBOs & contracted health plans to develop a detailed Corrective Action Plan (CAP) if a deficiency was reported in its quarterly or annual financial reports
- Requires the DMHC to monitor the CAP process and provide final approval



The OPO: History

AB 1455 (Chapter 827, Statutes of 2000)

- § 1371
- Establishes new requirements for prompt payment of provider claims by health plans and their capitated providers/RBOs
- Requirements include timelines and penalties/interest on late paid claims
- “Quarterly Claims Settlement Practices Report” is required to be submitted for each licensed health care service plan
- Timely reimburse at least 95% of complete claims with correct payment including interest and penalties due





The OPO: History

AB 1455 Regulations

- §§ 1300.71 and 1300.71.38
- In situations where there is no specified rate to pay non-contracted providers rendering covered services (typically in the emergency context), payors are required to pay providers the reasonable & customary value of the service provided
- Directs the DMHC to streamline provider claims-payment processes and require internal dispute resolution processes for payors
- DMHC is required to develop a system of investigating and addressing unfair payment or billing patterns



The OPO: History

Key Milestones – Establishing the Block Transfer Process

- From mid-2001 until 1/1/2004, the only statute dealing with provider contract terminations was previous Section 1373.65, created by SB 1832 (1994)
 - The statute required 30-days notice to enrollees only if a Plan initiated a contract termination with a provider group
- On 1/1/2004, AB 1286 became effective and marked the true legitimization of the block transfer process with a revised statute (current Section 1373.65) directly on point requiring notices and filings regarding a provider group termination
- Rule 1300.67.1.3, requires the filing of specific Department-created forms and sets notice content criteria





The OPO: 2010

- Provider Solvency Unit
- Provider Complaint Unit
 - Balance Billing
 - Reasonable & Customary (R&C)
 - Independent Dispute Resolution Process (IDRP)
- Provider Network Unit (“Block Transfer Unit”)
- Provider Legal Services Unit



The OPO: Provider Solvency Unit

- Monitors the financial viability of RBOs
- Provides public reports as to the financial viability of RBOs
- Provides internal reviews of CAPs and oversee the CAP process
- Responsible for the collection, analysis and reporting of the AB 1455 claims settlement and dispute resolution requirements
- Examines the RBOs method for determining the R&C value of non-contracted services





The OPO: Provider Complaint Unit

- The PCU was established in response to AB 1455 as a 9-month pilot project that was implemented September 20, 2004 to ensure the prompt and accurate payment of claims to providers
- Receives & investigates complaints by physicians, hospitals, and other providers concerning payments of claims by health plans and capitated providers
- The PCU is responsible for investigating and providing meaningful and appropriate regulatory resolutions to claim payment disputes through identifying unfair payment practices and unfair billing patterns



The OPO: Provider Complaint Unit

- How it works...
- Providers must utilize the appropriate payer's "Provider Dispute Resolution Process" (PDRP) prior to submitting the complaint to the DMHC (per Rule 1300.71.38)
- Once the provider has completed the PDRP, and has obtained a written determination from the payer, the provider can submit the complaint to the PCU
 - The online complaint form can be accessed from the DMHC's website at <http://www.dmhc.ca.gov/providers/>;
 - The PCU reviews provider complaints for compliance with applicable law, and may direct the payer to make additional payment, refer the matter to our Office of Enforcement, or track and trend the information for ongoing compliance purposes





Welcome to California

The OPO: Provider Complaint Unit

- Since its establishment in 2004, the PCU has:

- Received more than 27,000 complaints

PCU Efforts Have Resulted In:

- 1,679 complaints for \$22,379,466.06

PCU Total Year to Date:

- 480 complaints for \$3,994,703.34
- Identified and effected change to unfair payer payment practices



What is IDR and how does it work?

- IDR is a project funded and administered by the DMHC and is similar to a “baseball style arbitration”
- Provider submits billed charge, and the payer submits its payment and a third party neutral determines which amount is closer to the R & C amount
- The process is voluntary
- The process is non-binding
- Results are non-precedential
- More information at http://dmhc.ca.gov/providers/clm/clm_idr.aspx





Welcome to California

The OPO: Provider Network Unit

- Effective February 2008, the Block Transfer Unit (Provider Network Unit) was moved under the OPO to centralize provider related functions and ensure provider information is consistent and predictable
- PNU reviews and renders decisions on the Block Transfer filings submitted by health plans for the movement of enrollees to new providers in order to ensure that network meets access and capacity standards, etc.



Welcome to California

The OPO: Provider Network Unit

- What is a Block Transfer?
 - A “block transfer” is the reassignment or redirection of 2,000 or more enrollees by a health plan from a provider group or hospital to other contracting providers resulting from the termination or non-renewal of a provider contract
- Filing Requirements
- If the contract actually terminates
 - Monitor access to care
 - Communicate with the Help Center





Block Transfer Statistics: Results from Contract Termination

2008 Calendar Year

Provider Groups	89 filings
Hospitals	259 filings
<u>Info Only</u>	<u>68 filings</u>
Total	416 filings

2009 Calendar Year

Provider Groups	106 filings
Hospitals	227 filings
<u>Info Only</u>	<u>59 filings</u>
Total	392 filings



Provider Challenges

- **Concerns regarding California's provider networks:**
 - Capacity issues
 - Increase in actual terminations
 - Shift in bargaining power between health plans and providers
 - Providers with exclusive admitting privileges at terminating hospital
 - Lack of specialty providers in certain network areas
 - Lack of willingness to continue state sponsored business
 - Increase in hospital bankruptcies and closures
 - Hospital systems' bargaining tactics





Challenges: Hospital Bankruptcies and Closures

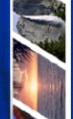
- Health plan contracting rates
- Inadequate Medicare and Medi-Cal payments
- Uninsured and underinsured Californians
- Demand for services/new medical technology
- Non-general acute care hospital competitors (e.g. specialty hospitals/clinics)
- Unfunded mandates (e.g. seismic safety, nurse staffing)
- Labor shortages and costs
- Spiraling construction costs



Challenges: Hospital Systems

- Hospital systems are trying to contract as an entire system (one goes out they all go out)
- Hospitals in a system are often the only viable alternate hospital for the terminating hospital, which limits the health plan's ability to redirect care or terminate a contract with a hospital system
- When a hospital purchase takes place, some hospitals will not accept the assigned contract, and refuse the current managed care contract





Welcome to California

“Health Care Reform in California: The End of the Beginning”

-Mark D. Smith, M.D., M.B.A.

- 2010 Federal Health Care Reform will transform the way Californians obtain and pay for health insurance
- Estimates are that once the law is fully implemented, 94% of the state's population will be covered by a health plan, through either an employer, a new health insurance exchange market, or expansions to public benefit programs such as Medi-Cal

• Source: California Healthcare Foundation



The 1st Interstate Highway





The OPO: Health Care Reform

- Provider Networks
- Financial Stability of Delivery System
- Health Information Technology (HIT) & Health Information Exchange (HIE)
 - Privacy & Security Standards
- Accountable Care Organizations (ACOs)



The OPO: Health Care Reform

• *Provider Networks*

- Timely Access Regulations – Implementation
- Medi-Cal Managed Care Expansion for Seniors & Persons with Disabilities (1115 Waiver) – Quarterly Network Adequacy Assessments





The OPO: Health Care Reform

- ***Financial Stability of Delivery System***

- Examining Provider Payment Provisions
 - Risk sharing arrangements
 - R&C rates for non-participating emergency room providers
 - Alternate payment models (including, but not limited to partial capitation payment models, payment bundling, and single care episode payments)
- DMHC Financial Solvency Standards Board
 - Next meeting 11/3



The OPO: Health Care Reform

- ***HIT & HIE***

- Focus efforts on the deployment of, and affordable access to, broadband services
 - California Telehealth Network
- Support HIT adoption by providers to meet “meaningful use” incentive payments (ARRA)
- Support the development of HIT-enabled alternative care approaches to address public hospital and provider shortages
- Support HIE linkages on a regional basis, to establish interoperable, sustainable technology
 - Privacy & Security Standards
 - CalPSAB





The OPO: Health Care Reform

• **HIT & HIE**

- Focus on establishing sustainable business models for HIT & HIE:
 - Determine the extent to which access to capital and loss of productivity inhibits the business case for sustainable adoption of HIT
 - Align incentives that will accelerate adoption by providers and emphasize applications that can drive quality improvement (including Disease Management Registries, EHRs, and e-prescribing)
 - Develop access to capital through grants & loans using cost effective financing options



The OPO: Health Care Reform

HIT & HIE

Critical Access Hospital HIT Financing Update

\$10 Million allocated from CA Health Care Investment Program

CAH need's present a unique situation –

Similar organizations, all with a specific financing need, within the same time period

Cost of Issuance paid from Grant Funds tied to Investment Program

Pooling Approach –

- Fund financing needs from one bond issue
- Cost savings
- Efficiencies





The OPO: Health Care Reform •ACOs

- From October 19 - November 19, 2010 all parties are
- invited to comment on the National Committee for Quality Assurance's (NCQA) 2011 Draft ACO Criteria

•NCQA defines ACOs as:

- Provider-based organizations that take responsibility for meeting the health care needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs

- Common characteristics are clear but there is no standard or uniform definition of an ACO for the commercial market, yet



The OPO: Health Care Reform •ACOs

- In California ACOs have prototypes: multispecialty group practices, and Independent Practice Associations (IPAs)

- ACOs shift focus from patient volume and market share toward capacity to manage and analyze the care for which the ACO will be held accountable

- That shift includes new financial and integration challenges for the ACO partners





The OPO: Health Care Reform •ACOs

- Organization and governance
- Antitrust
- Privacy and patient data
- Physician payments (Anti-Kickback, Stark, Civil Monetary Penalty)
- State-specific medical and managed care requirements
 - Corporate practice of medicine
 - Health plan licensure
 - Risk sharing



The OPO: Health Care Reform

•Next Steps...

- Wrap all of the policy, business, and legal issues relating to ACOs together to find the right regulatory response
- Recognize the need for flexibility, evaluation, and feedback as reforms evolve
- Focus review and oversight on the Department's core function of promoting the delivery and quality of health care

