



County Organized Health System Medi-Cal Plans

Managed Care in California Series

Issue No. 3

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Introduction to the County Organized Health System Model of Medi-Cal Managed Care

In certain counties, Medi-Cal managed care is operated by a single County Organized Health System (COHS). In 1981, Congress passed a federal law aimed at encouraging the proliferation of Medicaid managed care programs by allowing states to waive certain Medicaid Act requirements if they contracted with government-run prepaid plans that did not federally qualify as Health Maintenance Organizations.¹ Under federal law, only a limited number of such plans may operate, and their enrollment is capped.² In 1982, California legislation authorized the first COHS to deliver managed care services to Medi-Cal beneficiaries.³ Each COHS is created by a county board of supervisors and governed by an independent commission.⁴ In COHS counties, a single plan serves all Medi-Cal beneficiaries who are enrolled in managed care.

There are currently six COHS, operating in 22 counties.⁵ They are:

- CalOptima (Orange County);
- CenCal Health (Santa Barbara and San Luis Obispo Counties);
- Central California Alliance for Health (Santa Cruz, Monterey, and Merced Counties);
- Gold Coast Health Plan (Ventura County);
- Health Plan of San Mateo (San Mateo County); and
- Partnership HealthPlan of California (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties).

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Almost all Medi-Cal eligible beneficiaries in COHS counties, including those enrolled in both Medi-Cal and Medicare (“dual-eligibles”) and individuals with a share of cost, are mandatorily enrolled into the COHS plan. Undocumented individuals and others who qualify for certain limited benefits are excluded from Medi-Cal managed care in most COHS counties.⁶

Overview of COHS Regulation

Medi-Cal managed care plans are generally subject to: (1) consumer protections provided by the California Knox Keene Act and overseen by the Department of Managed Health Care (DMHC);⁷ (2) federal and state rules and regulations for Medi-Cal;⁸ and (3) terms set forth and agreed upon in contracts between the plans and the Department of Health Care Services (DHCS).⁹

Unlike other Medi-Cal managed care plans, COHS plans are not required to obtain Knox Keene licensure for their Medi-Cal lines of business, and unless they choose to obtain a Knox-Keene license, they are not directly regulated by the DMHC.¹⁰ Per the 1982 legislation, COHS enter into a contract with the state and are expressly exempt from Knox-Keene Act licensure.¹¹ “Rather than operating under specific statutory mandates, the county is bound by the rules, terms, and conditions negotiated by the contract.”¹²

Specific federal and state authority provide for this exemption.¹³ While federal authority mandates that COHS plans satisfy Knox Keene requirements, without being subject to licensure, the precise scope of this mandate is untested.¹⁴ The contract between COHS plans and DHCS encompasses many—but not all—Knox Keene protections.¹⁵

Consumer advocates should be aware of the differences in the protections available in COHS plans from those provided by the Knox Keene Act licensed plans, in order to understand the rules and consumer protections that are available within the plans and to know what regulatory agency is responsible to monitor and enforce compliance. Key differences are explored, below.

Covered Services

DHCS requires COHS plans to provide a broad scope of services that at minimum mirrors benefits under Medi-Cal fee-for-service (FFS).¹⁶ Some services are considered “carve-outs,” meaning they are paid for through the Medi-Cal fee-for-service program or a separate waiver program. Which services are “carved-out” from COHS plan contracts varies depending on the county and plan, and may include: Home and Community Based Services,¹⁷ services provided under the HIV/AIDS Home and Community Based Services Waiver,¹⁸ Specialty Mental Health Services,¹⁹ Dental services,²⁰ and Alcohol and Substance Use Disorder Treatments.²¹ Similar to other Medi-Cal managed care plans, COHS plans must ensure coverage of all medically necessary services, but need not cover certain “carved-out” drugs, including certain psychotherapeutic drugs, and HIV/AIDS medications.²² Those “carved-out” drugs are

provided on a fee-for-service basis, instead.²³ Responsibility for case management and coordination of all “carved-out” services and medications remains with the COHS.²⁴

Accessing Services

COHS network adequacy requirements—i.e., standards relating to the availability of providers within a network—are largely consistent with those applicable to Knox Keene licensed plans.²⁵ However, unlike Knox Keene licensed plans, COHS plans are not required to set geographic (distance) access standards for hospitals or ancillary services, such as pharmacies or laboratories.²⁶

As with all managed care organizations, COHS are permitted to employ various utilization review techniques and cost control measures such as requiring an enrollee to obtain prior authorization for a procedure, service or item. While all Medi-Cal plans must provide any covered benefit that is medically necessary, utilization review processes can have a practical effect on access to care. The criteria a COHS plan uses to determine whether to authorize, modify, or deny a request for services must be evaluated “regularly” and updated as necessary.²⁷ The Knox Keene Act establishes a more defined protection, requiring licensed plans to review such criteria at least annually.²⁸ Moreover, unlike Knox-Keene licensed plans, which must provide their evaluation tools to the public upon request, the Medi-Cal contract does not require this of COHS plans.²⁹

Complaint Resolution

By contract, COHS plans must maintain and implement a complaint resolution process for service denials that is consonant with most of the requirements set forth by DMHC rules and regulations.³⁰ There are four key areas in which the COHS complaint resolution process may differ from those of other Knox-Keene-licensed plans:

(a) COHS plans are not required to provide Independent Medical Reviews. The Knox Keene Act requires licensed health plans to provide enrollees with an internal grievance process, and an external review process. Grievances involving disputes over the medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational, may be sent to an external clinical review process known as Independent Medical Review (IMR) if still unresolved after 30 days.³¹ This external review process is administered by the DMHC, who contracts with an IMR organization to conduct the IMRs. The findings at the IMR are binding on plans and the plans are required to pay the cost of the review.³²

COHS plans are not required to have an external review process other than the right to a Medi-Cal state fair hearing. Therefore, a beneficiary’s only options for appealing disputed claims are limited to filing an internal grievance with the plan and/or requesting a Medi-Cal state fair hearing; beneficiaries may be

also able to obtain help resolving problems from the DHCS Medi-Cal Managed Care Ombudsman Office.³³

(b) Beneficiaries cannot file a complaint with DMHC if they have a problem with their plan. Unlike Knox-Keene licensed plans, COHS plans are exempt from DMHC oversight, including any regulation of the grievance system for their Medi-Cal line of business.³⁴ In Knox-Keene licensed plans, enrollees may file a complaint with DMHC if their plan fails to resolve a grievance to the enrollees' satisfaction. Where IMR is not available—for example, for disputes over whether a particular service is a covered benefit—enrollees may file a DMHC complaint to obtain external review. In non-Knox-Keene licensed COHS plans, enrollees cannot seek DMHC' assistance in resolving these cases.³⁵ Nevertheless, a beneficiary may still contact the DHCS Medi-Cal Managed Care Ombudsman Office to report a problem with his or her plan, and may request a Medi-Cal fair hearing wherever there is a delay, denial, termination, suspension or reduction of services.³⁶

(c) COHS Plans Have Greater Flexibility Regarding Instances in Which They Authorize a Second Opinion. All plans must ensure that their utilization management programs permit enrollees to receive a second opinion at no cost.³⁷ Whereas the Knox Keene Act expressly sets forth reasons for which a second opinion must be authorized, such as when an enrollee questions the reasonableness of a recommended surgical procedure, COHS plans have greater discretion over when to allow enrollees to obtain a second opinion.³⁸

(d) COHS Plans are not Required to Provide an Online Grievance Form. Knox Keene Act plans must provide enrollees with a right to file grievances online, thereby simplifying the process for some beneficiaries.³⁹ By contrast, COHS plans need only to make information on grievance procedures, including printable copies of any necessary forms, available online.⁴⁰ Currently, all COHS plans, except for Gold Coast Health Plan (serving Ventura county), provide an online grievance form for Medi-Cal beneficiaries.

Continuity of Care

Non Knox-Keene-licensed COHS plans are not required to follow Knox-Keene Act "continuity of care" protections that entitle enrollees the option to continue receiving care from an out-of-network provider . The Knox Keene Act requirements permit enrollees with certain qualifying health conditions to continue their care with an out-of-network provider for a period of time.⁴¹ One exception to this exemption from Knox-Keene is that Partnership, a COHS plan, must provide continuity of care according to the Knox-Keene Act provisions in eight northern counties: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.⁴²

And even when they are not subject to the specific Knox-Keene continuity of care protections, all COHS plans are subject to the same continuity of care requirements that apply to other Medi-Cal plans for

certain populations. Special continuity of care protections apply to seniors, people with disabilities, certain dual eligibles, certain children who were previously enrolled in the former Healthy Families program, and certain adults who were previously enrolled in the former Low Income Health Programs.⁴³

Conclusion

Consumer protections for COHS plan enrollees incorporated by contract with DHCS may not ensure the same level of care quality and accessibility as provided by the Knox Keene Act. Additionally, DMHC can exercise only limited oversight of COHS plans because most COHS plans are not licensed under the Knox Keene Act. Understanding these differences is important for advocates to determine what options are available to assist Medi-Cal beneficiaries currently receiving coverage through a COHS plan. This is particularly important as the number of counties using the COHS model of Medi-Cal managed care continues to expand.

ENDNOTES

¹ OMNIBUS RECONCILIATION ACT OF 1981, ch. 2, sec. 2176, § 1915, 79 Stat. 286; *see also* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40989, 40994 (June 14, 2002) (preamble language giving history of regulation of “health insuring organizations” or HIOs—the federal name for COHS plans); 42 U.S.C § 1396u-24(a)(3)(C); 42 C.F.R. § 438.2 (federal definition of HIO).

² Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 9517(c), 100 Stat. 82 (1986) (codified as a note under 42 U.S.C § 1396b) (allowing, as of 2008, up to 5 HIOs, serving not more than 16% of Medi-Cal beneficiaries, to operate in California).

³ CAL. WELF. & INST. CODE §§ 14087.5-.95.

⁴ *Id.* § 14087.54.

⁵ Health Plan of San Mateo, while designated as a COHS for the purposes of California state law, “is not considered an HIO by Federal standards because it became operational after January 1, 1986.” CENTERS FOR MEDICARE & MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, AMENDED MARCH 19, 2014, CALIFORNIA BRIDGE TO REFORM DEMONSTRATION ¶ 53, *available at* <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-ar.pdf>; *cf.* CAL. WELF. & INST. CODE § 14087.51 (authorizing the establishment of a COHS in San Mateo).

⁶ *See generally* CAL. DEP’T OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE PLANS VOLUNTARY & MANDATORY ENROLLMENT COVERAGE BY MEDI-CAL AID CODES (2014), *available at* <http://www.dhcs.ca.gov/services/Documents/AidCodeChart.pdf>. Napa, Solano, and Yolo counties mandatorily enroll undocumented individuals who qualify for certain limited benefits. *Id.*

⁷ *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

⁸ *See generally* 42 U.S.C. 1396; CAL. CODE REGS. tit. 22, §§ 50000-59999.

⁹ *See generally* CAL. DEP’T OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE BOILERPLATE CONTRACTS (2014), *available at* <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

¹⁰ 42 U.S.C § 1396b note; CAL. WELF. & INST. CODE § 14087.95. Mandating Knox Keene licensure for COHS plans’ Medi-Cal lines of business would require state-level legislative change.

¹¹ *See* CAL. WELF. & INST. CODE § 14087.5 (“The California Medical Assistance Commission may negotiate exclusive contracts with any county which seeks to provide, or arrange for the provision of the health care services provided under this chapter.”; *id.* § 14087.95 (“Counties contracting with the department pursuant to this article shall be exempt from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.”).

¹² *Keffeler v. P’ship Healthplan of California*, 224 Cal.App. 4th 322, 332 (2014) (citing CAL. WELF. & INST. CODE § 14087.55).

¹³ *See supra* note 10.

¹⁴ 42 U.S.C § 1396b note. Federal legislation also limits the percentage of Medi-Cal beneficiaries who can belong to a COHS to 16 percent, and increasing the number of COHS plans (although not the number of counties in which the existing COHS plans operate) would require federal legislative change. *Id.*

¹⁵ *See generally* CAL. DEP’T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COHS COUNTIES, (2014), *available at* <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.

¹⁶ *Id.* at Ex. A, Att. 10, § 1.

¹⁷ *Id.* at Ex. A, Att. 11, § 11(C). For a full listing of carved out services, *see id.* at Ex. E, Att. 1, “Covered Services” (beginning at “Covered Services do not include:”).

¹⁸ *Id.* at Ex. A, Att. 11, § 15.

¹⁹ *Id.* at Ex. A, Att. 11, § 7.

²⁰ *Id.* at Ex. A, Att. 11, § 16.

²¹ *Id.* at Ex. A, Att. 11, § 8.

²² *Id.* at Ex. A, Att. 10, § 8(F).

²³ *Id.* at Ex. A, Att. 10, § 8(F)(5). In order to qualify for reimbursement, a pharmacy must be enrolled as a provider in the Medi-Cal FFS program.

²⁴ *Id.* at Ex. A, Att. 11, § 2.

²⁵ For more information about network adequacy in Medi-Cal managed care plans, see our companion piece: NAT'L HEALTH LAW PROG., MEDI-CAL MANAGED CARE IN CALIFORNIA SERIES #1: NETWORK ADEQUACY LAWS IN MEDI-CAL MANAGED CARE PLANS (2014), available at <http://www.healthlaw.org/publications/search-publications/network-adequacy-laws-in-medi-cal-managed-care-plans>.

²⁶ See generally CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 15 at Ex. A, Att. 9.

²⁷ *Id.* at Ex. A, Att. 5, § 2.

²⁸ CAL. HEALTH & SAFETY CODE § 1371.4(c).

²⁹ *But cf. id.* at § 1363.5(b)(5) (requiring that Knox Keene licensed plans make utilization management criteria available to the public upon request).

³⁰ CAL. CODE REGS., tit. 28, §§ 1300.68, 1300.68.01.

³¹ CAL HEALTH & SAFETY CODE § 1374.30.

³² *Id.*

³³ 42 C.F.R. § 431.220; CAL. CODE REGS., tit. 22, § 50951; Cal. Dep't of Health Care Servs., Medi-Cal Managed Care Division Office of the Ombudsman, <http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx> (last visited Sep. 23, 2014). For information about requesting a fair hearing, see our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #4: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (forthcoming 2014); see also HEALTH CONSUMER ALLIANCE, *supra* note 50 at 3-4; HEALTH CONSUMER ALLIANCE, WHAT IF MEDI-CAL SAYS "NO"? (2008), available at <http://healthconsumer.org/fs002LAeng.pdf>.

³⁴ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 15, Ex. A, Att. 14, § 1 (exempting COHS from 28 CCR §§ 1300.68(c), (g), (h), and 1300.68.01(b)).

³⁵ *Id.*

³⁶ See *supra* note 33.

³⁷ 42 C.F.R. § 438.206(b)(3); see also, CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 15, Ex. A, Att. 5, § 1; CAL. HEALTH & SAFETY CODE §§ 1383.1, 1383.15.

³⁸ CAL HEALTH & SAFETY CODE § 1383.15.

³⁹ *Id.* at § 1368.04.

⁴⁰ CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 15, Ex. A, Att. 14, § 1 (incorporating subdivisions of 28 CCR § 1300.68).

⁴¹ See CAL. HEALTH & SAFETY CODE § 1373.96 (Knox Keene Act provisions relating to continuity of care).

⁴² See CAL. WELF. & INST. CODE § 14087.98(h) (incorporating, for COHS plans in specified counties, the provisions of Cal. Health & Safety § 1373.96).

⁴³ For more information about the specific consumer available to Medi-Cal beneficiaries, see ABBI COURSOLE, NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN MEDI-CAL (2013), available at <http://www.healthlaw.org/publications/continuity-of-care-in-medi-cal>, and ABBI COURSOLE, NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN THE TRANSITION FROM THE LOW INCOME HEALTH PROGRAM TO MEDI-CAL (2014), available at <http://www.healthlaw.org/publications/COC-in-transition-from-LIHP-to-MediCal>.