COVERED CALIFORNIA

PARTNER PRESENTATION:
CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

California Department of Managed Health Care

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DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

Our Accomplishments

2.6 MILLION CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

$86.3 MILLION

dollars assessed against health plans that violated the law

140 LICENSED HEALTH PLANS

94 FULL SERVICE

46 SPECIALIZED

$296.1 MILLION

dollars saved on Health Plan Premiums through the Rate Review Program since 2011

28.4 MILLION CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

96% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

Approximately **68%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan

December 31, 2021

$38.5 MILLION

dollars recovered from health plans on behalf of consumers

$177.8 MILLION

dollars in payments recovered to physicians and hospitals

What is the DMHC?

Regulator of full service and specialized health plans

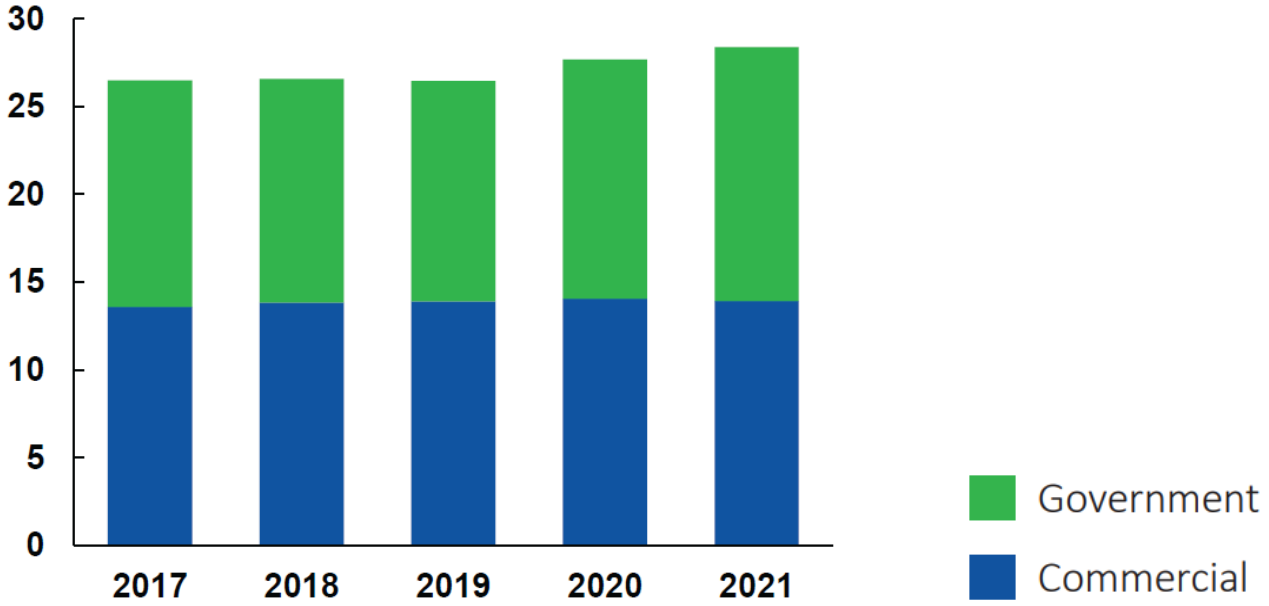
- All HMO and some PPO/EPO products
- Some large group and most small group & individual products
- Most Medi-Cal Managed Care plans
- Dental, vision, behavioral health, chiropractic and prescription drug plans
- Medicare Advantage (for financial solvency only)

Knox Keene Health Care Service Plan Act of 1975

- Consumer-sponsored legislation in 1999 created DMHC
- Health and Safety Code § 1340 et seq. & 28 CCR § 1000 et seq.
- Originally administered by the Department of Corporations
- Prior to the Affordable Care Act, the Knox Keene Act was considered the most comprehensive managed care regulation in the country

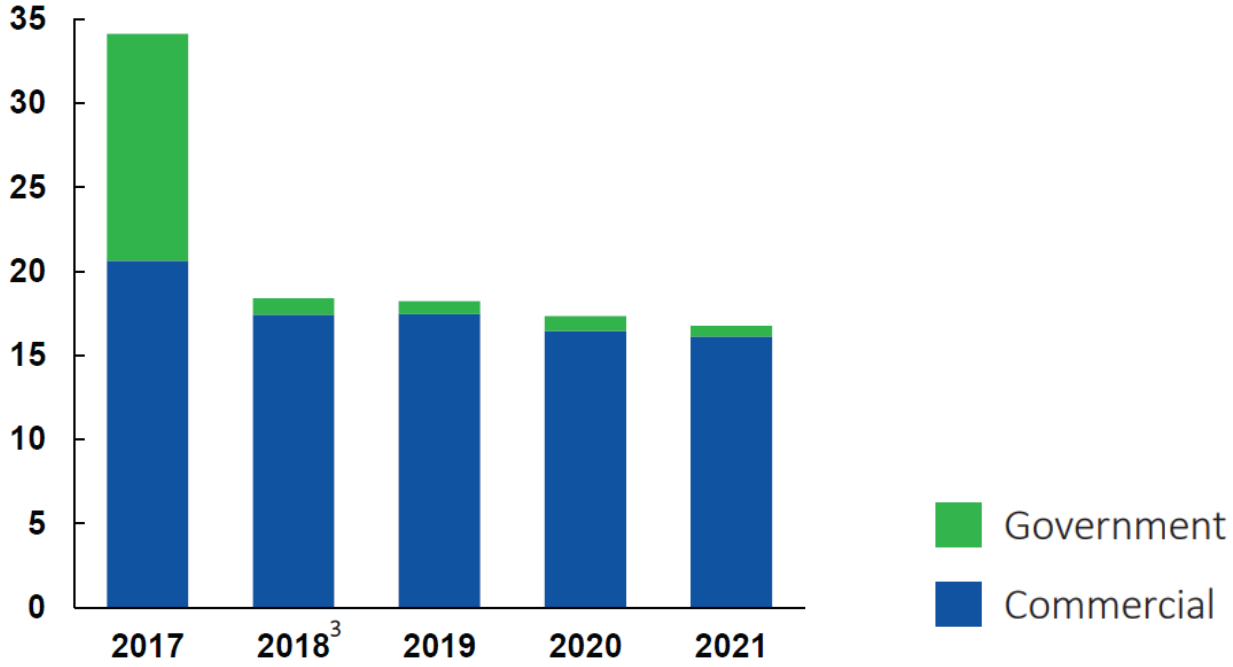
DMHC Enrollment Over Time

Full Service Enrollment (In Millions)



DMHC Enrollment Over Time

Specialized Enrollment (In Millions)



California Has Two State Regulators

DMHC

- Director appointed by the Governor
- Part of CalHHS and the Executive Branch
- Regulates health coverage only
- Health and Safety Code
- **28.4 million** health care consumers

CDI

- Commissioner elected by voters
- Separate constitutional entity from Executive Branch
- Regulates many forms of non-health insurance
- Insurance Code
- **1.1 million*** health care consumers

DMHC Regulates

- All HMO products
- PPO & EPO products
- Specialized plans (vision, dental, behavioral, chiropractic)
- Prescription drug plans
- Some large group and most small group & individual products
- **96%** of the commercial and public health plan enrollment
- **98%** of the state's health benefit exchange enrollment

CDI Regulates

- PPO products
- EPO products
- All indemnity products
- Some individual and some small group products

Health Coverage that is NOT Regulated by the DMHC

- CDI products
- Most Medicare coverage[1]
- Some Medi-Cal coverage (FFS and COHS)
- ERISA self-insured plans
- Private health benefit exchanges

What Does the DMHC Regulate?

- ***DMHC regulates "health care service plans."***
  - **Knox Keene Act Definition:**

    "Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."
    Health and Safety Code §1345(f)(1)

What Does the DMHC Regulate?

- **Translation:**

  “An entity that takes a set payment from a purchaser, to arrange and pay for a specific set of health care services.”

Types of Licenses

- Full Service
- Restricted – Formerly “Limited Licensees”
- Specialized
  - Dental
  - Vision
  - Behavioral Health
  - Chiropractic
  - Prescription Drug
- Discount
- Employee Assistance Program (EAP)

How Does the DMHC Regulate Plans?

- License plans and approve products
- Analyze provider networks
- Ensure basic health care services and mandated benefits are provided
- Monitor financial solvency
- Evaluate plan policies and procedures
- Resolve grievances and appeals
- Track enrollee complaints
- Enforce the law

How Does DMHC Oversee Providers?

- The DMHC does not license providers
- The DMHC monitors Risk Bearing Organizations (RBO):
  - Review RBO financial reports
  - Monitor RBO solvency
  - Ensure claims are paid timely
  - Resolve provider disputes
- Goal is to prevent failures that could harm enrollees, plans and other providers

Help Center

Assists consumers with health care issues and ensures that managed care patients receive the medical care and services to which they are entitled.

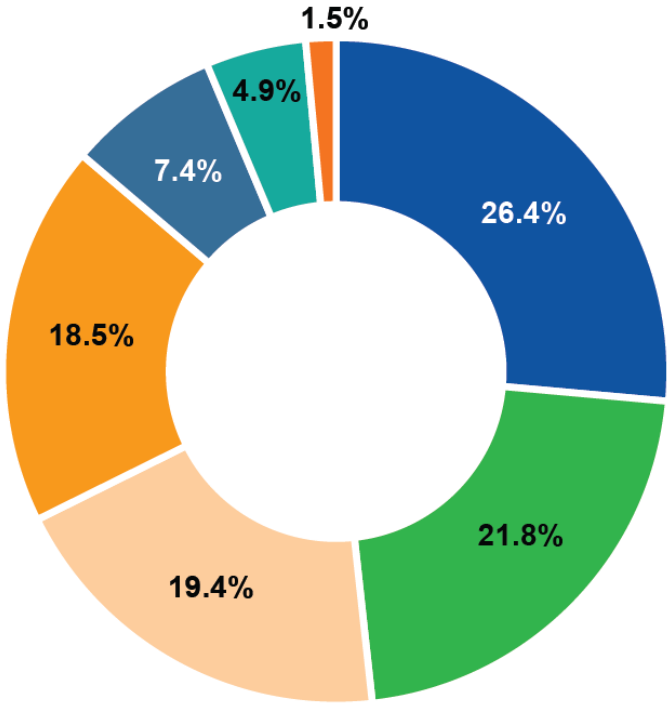
- Contact Center
- Division of Legal Affairs and Policy
- Independent Medical Review/Complaint Branch
- Provider Complaint Unit

2021 BY THE NUMBERS

HELP CENTER

122,666	CONSUMERS ASSISTED[9]
106,641	TELEPHONE INQUIRIES
10,771	CONSUMER COMPLAINTS[10]
3,747	IMRs CLOSED[11]
$2.4 M	RECOVERED FOR CONSUMERS
1,507	NON-JURISDICTIONAL REFERRALS
6,350	PROVIDER COMPLAINTS
$10.2 M	RECOVERED PROVIDER PAYMENTS
22	NON-EMERGENCY SERVICES IDPR CASES COMPLETED

Consumer Complaints Resolved in 2021



- **1.5%** - Coordination of Benefits[9]
- **4.9%** - Enrollment
- **7.4%** - Access to Care
- **18.5%** - Provider Customer Service
- **19.4%** - Health Plan Customer Service
- **21.8%** - Benefits/Coverage
- **26.4%** - Claims/Financial

Independent Medical Reviews (IMRs)

Complaints

A Consumer Complaint is a general complaint about a health plan, provider, or medical group, including:

- Delays in getting an appointment, referral, or authorization
- Claims, billing and co-payment issues
- Terminations or cancellations of health coverage
- Access to translation and interpretation services
- Finding an in-network doctor, hospital or specialist
- Doctor or hospital is no longer with your health plan (Continuity of Care)

Independent Medical Review

- Health plan denies, modifies, or delays a health care service, treatment or medication based on medical necessity .
- An objective review by doctors outside your health plan.
- Apply for an IMR within six months after your health plan sends you a written decision about your issue.
- In most cases, IMRs are decided within 45 days. Faster for urgent cases.
- If a complaint does not meet the criteria for an IMR, it will be processed as a Consumer Complaint.

IMR Program

- A consumer can request an IMR if the health plan denies, modifies, or delays a health care service, treatment or medication.
- Requests eligible for IMR for:
  - Medical Necessity (MN)
  - Experimental/Investigational (E/I)
  - Reimbursement request for Emergency services (ER)
- Benefit coverage exclusion denials are NOT eligible for IMR

IMR Program Eligibility

- The consumer is a member of a DMHC licensed health plan.
- The consumer has completed the health plan's grievance process (exception E/I denials and expedited cases).
- The consumer has applied for an IMR within 6 months after the health plan sends a written decision (denial).
- The consumer has provided a signed IMR application.

FAQ

Who is not eligible for IMR?

- Medicare enrollees.
- Medi-Cal fee-for-service members (Medi-Cal members who are not in a managed care plan).
- Members of self-insured and self-funded plans.
- An enrollee disputing a workers' compensation claim.

Health Plan Grievance Process

- First file a grievance or complaint with the health plan.
- If there is an immediate threat to the Enrollee's health, they should contact DMHC for immediate assistance.
- A complaint can be filed with the health plan by phone, by mail, or on the plan's website.
- If the plan upholds their denial through the grievance process or if you have not received the plan's decision within 30 days, file an IMR or complaint with DMHC.

Health Plan Grievance Process

- Plans are required by law to resolve enrollee complaints within 30 days or 72-hours for expedited grievance.
- If the issue has not been resolved or the consumer is not satisfied with the decision, they can file an IMR/Complaint with the DMHC.
- **If the health condition is urgent, the consumer may seek immediate assistance from the DMHC.**

The Path of IMR

- The patient applies for an IMR at DMHC.
- DMHC will determine if it meets the criteria to be expedited and if it qualifies for IMR or Complaint Process.
- If it qualifies, the request is assigned to a Medical Expert by IMRO.
- The Health Plan submits medical records to the IMRO.
- The IMRO upholds or overturns the Health Plan decision.
- The DMHC promptly adopts the decision.

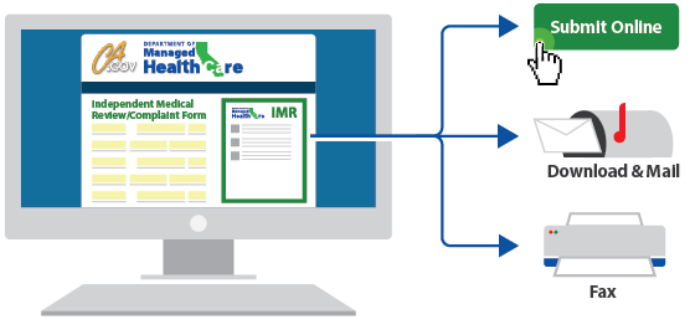
How Long Does an IMR Take?

- IMRs are typically resolved within 45 days
- Expedites within 7 days after the case has qualified for an IMR and the required documentation has been received by the Independent Medical Review Organization (IMRO).
- Once an IMR decision is adopted by the DMHC, it is final and binding.

EXPEDITES
7 DAYS

How to Apply

- Visit www.HealthHelp.ca.gov and navigate to the page Submit an Independent Medical Review/Complaint Form.
- You will find the IMR/Complaint Form Links.
- The online IMR/Complaint Form is available in either English or Spanish.
- The printable form is available in 17 languages and may be submitted by mail or fax.



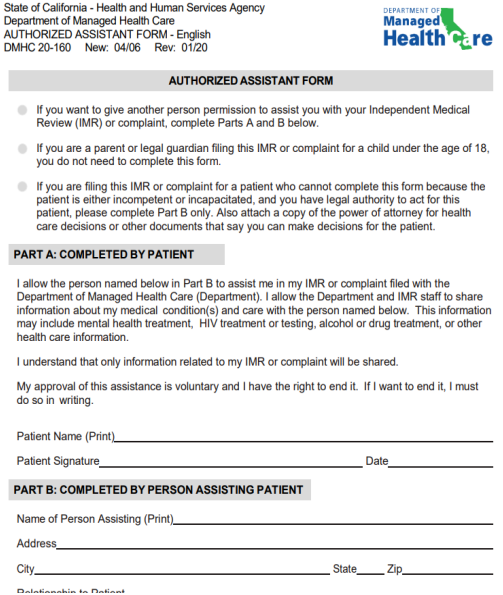
Where is the IMR/Complaint Form?

Tips for Completing the IMR/Complaint Form

- Provide as much information as possible on the form and attach additional notes or documentation. Include names of treating providers.
- If there is an immediate threat to the patient's health, indicate on the form that it is an urgent issue that requires an expedited review.
- If the patient has been seen by out-of-network providers or out-of-state providers, include those medical records with the IMR/Complaint Form submission.

Tips for Completing the IMR/Complaint Form

- The person filing the IMR may have someone assist them with the process with their consent.
- The patient must sign and date the IMR form and sign and date the Authorized Assistant Form, if assistance is needed.



State of California - Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM - English
DMHC 20-160 New: 04/06 Rev: 01/20

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)_____

Patient Signature_____ Date_____

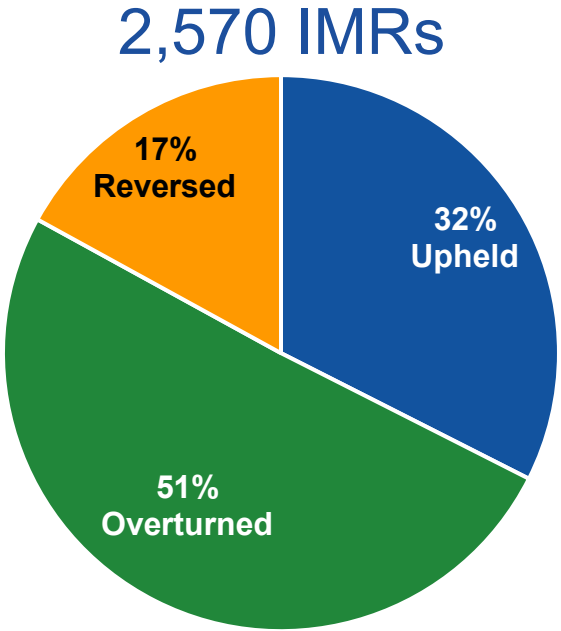
PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)_____

Address_____

City_____ State____ Zip_____

IMR Outcomes for 2021



DMHC Help Center Contact

Questions?