We are all concerned about the quality of health care in many settings, and the focus of the industry and the public in the past has been primarily on the hospital setting. The Joint Commission has been in place since 1951 to monitor care in hospitals and ambulatory health care facilities, but what about quality in other aspects of health care, for instance, managed care?

The term “managed care” includes all health insurance products that use systems and techniques to control the use of health care services, and covers most of the continuum of care. This includes a review of medical necessity, incentives to use certain providers, and case management. These products are familiar to most people as HMOs and PPOs. In practice, an HMO, (Health Maintenance Organization), is an insurance plan under which an insurance company controls all aspects of the health care of the insured. In the design of the plan, each member is assigned a primary care physician (PCP) who is responsible for the overall care of members assigned to him/her. Specialty services usually require a specific referral from the PCP to the specialist. Non-emergency hospital admissions also may require specific pre-authorization by the PCP or the plan. Typically, services are not covered if performed by a provider not specifically approved by the HMO, unless it is an emergency situation as defined by the HMO. Financial sanctions for the use of emergency facilities in non-emer gent situations were once an issue; however, prudent layperson language now applies to all emergency service utilization and of penalties have decreased.

A PPO, (Preferred Provider Organization), is defined as some combination of hospitals and physicians that agree to render particular services to a group of people, perhaps under contract with a private insurer, i.e., a health care delivery system, which contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subject to co-payments and deductibles.

In many health plans, some services can be accessed through self-referral, bypassing the PCP. One example of this is mental health and chemical dependency care, collectively known as “behavioral health care”. Some health plans carve out this service to a specialty health plan, in effect, creating a sub-contractor relationship with the enrollee. Such enrollees, typically, have a separate access, toll-free telephone number to call for behavioral services. Provider contracting, utilization management, and sometimes claims payment are usually done by the specialty...
health plan. While this is a streamlined access point for the enrollee, the arrangement can create discontinuity of care due to the absence of the PCP in the referral process. Most health plans are well aware of this potential and take care to improve continuity and coordination of care. The enrollee’s written consent must, of course, be obtained in order for this to occur. Regulatory and accreditation organizations also address this issue within their requirements.

It has long been the belief that managed care needs to be regulated since consumer choice is limited in a managed care environment. A person must choose a primary care physician and usually needs a referral before seeing a specialist. Whenever there is limited patient choice, there is a potential for access issues and negative outcomes of care. Hence, regulations grow around the industry.

Healthcare is a very heavily regulated industry in the State of California. Most of us are familiar with the California Department of Health Services (DHS). The DHS has five major areas of activity. They are:

- Licensing, 118 different types of health care facilities, (as of 5/8/07) and providers, (a total of over 6,000), so that they can legally do business in California.
- Certifying to the federal government, health care facilities and providers that are eligible for payments under the Medicare and Medicaid (Medi-Cal) programs.
- Accepting and investigating over 11,000 complaints each year.
- Regarding concerns expressed about care provided by these health facilities and providers.
- Certifying that over 160,000 nurse assistants, home health aides, and hemodialysis technicians, can provide specific services; and, approving training programs for these health care worker categories, and licensing over 3,000 Nursing Home Administrators and approving over 100 Continuing Education Providers.
- Providing Consumer, Education, and Provider Education to improve the quality of health care.

**Department of Managed Health Care (DMHC)**

A related agency, one with which we are perhaps not so familiar, is the California Department of Managed Health Care (DMHC), or “the Department.”

As part of the California state government, the Department maintains offices in Sacramento and Los Angeles. The DMHC has responsibility for seeing that all managed care health plans in the state abide by the California managed care laws and regulations, which include some of the strongest patients’ rights laws in the nation, and remain financially stable. Since July 1, 2000, the Department has had administrative responsibility for the execution of California state laws relating to health plans and ensuring that these health plans provide enrollees with access to quality health care, while protecting and promoting the interests of enrollees. Its scope includes full service health plans and specialty health plans, e.g., mental health, vision and dental plans.

(Prior to July 1, 2000, the Department of Corporations regulated managed health care in California.)

The Department describes its vision and mission on its website (http://www.dmhc.ca.gov), as follows:

**Vision:** To be nationally recognized. Health care policy experts, and establish national benchmarks for Health Maintenance Organization regulations, policy, patient advocacy, and consumer awareness.

**Mission Statement:** The people of the Department of Managed Health Care work toward an affordable, accountable, and robust managed care delivery system that promotes healthier Californians. Through leadership and partnership, the Department shares responsibility with everyone in managed care to ensure aggressive prevention and high quality health care, as well as cost-effective regulatory oversight.

In practice, the Department has several functions:

**Surveys:** California Managed Care law (Knox-Keene Health Care Service Plan Act of 1975), as amended (the “Act”), requires the DMHC to conduct a routine medical survey of each licensed full service and specialty health plan every three years. The medical survey is a comprehensive evaluation of the plan’s compliance with the Act, and Title 28 of the California Code of Regulations (“CCR”), in the following health plan program areas:

- Quality Management
- Grievances and Appeals (member...
Filing and Reporting: The DMHC maintains a great deal of information about each of the health plans it licenses. This information includes licensing and financial data that have been provided by plans and is used to ensure that health plans provide medically necessary services to Californians and that plans stay financially solvent to be able to provide access to care.

One of the goals of the Knox-Keene Act is to ensure the financial stability of HMOs in California so that consumers are protected. In order to achieve this goal, the Act and its underlying regulations mandate that HMOs file specific financial statements with the Department, which has full jurisdiction over the plans. The DMHC, web site also provides a link for plans to submit their required Quarterly Grievance, Reports, Quarterly and Annual Claims Settlement Practices Reports, Annual Provider Dispute Resolution Reports, and Block Transfer Filing Forms. (used when health plans must transfer a group of enrollees from one provider or hospital to another due to termination of the provider or hospital).

Any individual may access certain information about any health plan licensed through the DMHC, such as financial, reporting, medical surveys, and investigative surveys, as well as any enforcement actions taken by the Department. This can be done through the web site or by contacting the Department directly.

Enforcement: The goal of the Office of Enforcement is to ensure compliance with the law and regulations. It investigates complaints and issues citations for non-compliance. The Office also provides technical assistance to health plans and enforces the Knox-Keene Act to ensure that health plans provide quality care.

Notes from NAHQ
By Kathy Chai

Heidi Benson, our current NAHQ President has had a great deal of information to share. I will recap some of her President’s message here. Please feel free to contact Heidi at heidi.benson@lpnt.net if you would like to speak with her directly.

On May 16–18, 2007, a 21-member task force met to assess NAHQ’s governance structures and processes. There was strong consensus among us that changes were needed if we were serious about optimally meeting the needs of our diverse healthcare profession, developing leaders, engaging members in important work, improving two-way communication, and achieving our association’s vision.

To quote George C. Lichtenberg, “I cannot say whether things will get better if we change; what I can say is they must change if they are to get better.”

Within the next month, the board will share recommendations from the Governance Assessment Task Force with the Leadership Council, and team leaders. Further opportunities to discuss the proposal will occur at the national conference.

Other changes you’ll enjoy during the upcoming months will include the formal unveiling of NAHQ’s new visual identity and messaging campaign at the conference in Boston. We also plan to release the first issue of a new and improved newsletter, NAHQ E-News, in late summer. NAHQ is also improving the appearance and feel of its President’s message here. Please feel free to contact Heidi at heidi.benson@lpnt.net if you would like to speak with her directly.

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Managed Care

continued from page 17

ance with the Knox-Keene Act through timely, aggressive action against health plan violations. It is also responsible for handling the litigation needs of the DMHC, representing its in actions to enforce the managed care laws.

When a health plan violates the Act, the Director of the DMHC is authorized to take a variety of actions. This may include assessing administrative, civil and criminal penalties. It may also include issuing a cease and desist order, requiring the plan to stop the offending action. Under all of these circumstances, the plans are afforded due process protections and given notice and a hearing to contest or defend their actions. As a final alternative, health plans have recourse through the court system.

National Committee on Quality Assurance (NCQA)

In addition to meeting the licensing requirements outlined in the Knox-Keene Act and monitored by the DMHC, California managed care plans have the option of becoming accredited by the National Committee on Quality Assurance (NCQA). NCQA is a voluntary activity, a choice to be made by the officers of the health plan. To be accredited by NCQA means that the health plan has demonstrated excellence not only in the core systems and process that make up the health plan but the actual results that the plan achieves on key dimensions of care and service, as well. Over the years, most plans have learned that NCQA accreditation is necessary if they want to remain competitive with purchasers of health care. The different aspects evaluated by NCQA for an HMO are quality improvement (QI), utilization management (UM), credentialing and recredentialing (CR), members’ rights and responsibilities (RR), standards for member connections (MEM), and HEDIS®/CAHPS® performance measures. HEDIS focuses on rigorous outcomes of preventive and chronic care, and CAHPS is a satisfaction survey about dimensions of care and service of the health plan or PPO.

NCQA offers accreditation programs for HMOs, PPOs, managed behavioral health organizations (MBHOs), new health plans, disease management programs, and credentialing, verification organizations (CVOs), as well as Quality Plus, a more recent program designed to include newer models of plans, such as consumer-directed plans. NCQA’s focus is primarily on the outcomes of care and not as much on the structure and processes of the health plan, which differentiates the organization from its competitors. NCQA does not survey any aspect of a plan’s financial operations, nor does it survey vision or dental plans. NCQA’s most recent products focus on physician practices and include diabetes recognition, cardiovascular recognition, and physician practice connections. Employer groups and health plans nationally use these recognition programs to institute pay for performance (P4P) systems. P4P rewards physicians for improving quality outcomes of care and is used widely in California. For the past two years, California has hosted the national P4P summit because of its early programs in P4P with Integrated Healthcare Associates and the Pacific Business Group on Health. DMHC is mandated by law to make revisions to its regulations; it is affected by legislative Health Care Bills, which in turn direct the changes in the regulations. Revisions are not made every year, taking time to be completed by Legal Oversight. Not mandated by law, as is the DMHC, NCQA has the flexibility to make changes at will, and has done so every year in revising its standards. The organization continues to obtain input from the managed care industry, from providers of healthcare,
from purchaser groups (including the federal Centers for Medicare and Medicaid Services, CMS and state policy makers), and national consumer groups, and attempts to meet the needs of each to the extent possible.

Many thanks to the following individuals for review and comment:
Eileen Innecken, CPHQ, Director of Compliance, U.S. Behavioral Health Plan, California.

Susan K. Moore, RN, MHSA, Managed Healthcare Resources, Inc., NCQA consultant and surveyor.

Grace Jimenez-Hennessy, RN, BSN, MHA, Staff HealthCare Service Plan Analyst, California Department of Managed Health Care.

Footnotes
1. Health Plan Employer Data and Information Set (HEDIS) is a tool used by more than 90% of U.S. health plans to measure performance on important dimensions of care and service. Offered for commercial, Medicare, and Medicaid plans, there are approximately 25 measures for each.

2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) evaluates patients’ experience with care and service. Its use is not exclusive to NCQA.

References:

For CEU post test see page 52