Medi-Cal HMO Considers Merger to Keep Contract

■ **Health:** State proposal would let Molina continue Inland Empire services if it complies with federal law.

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Molina Medical Centers, a $90-million company battling allegations that it has not complied with federal law, is considering a merger or affiliation with another HMO in a bid to retain its status as a full-service Medi-Cal contractor, a spokeswoman confirmed Friday.

The report capped a week of intense negotiations between Molina and the state, prompted by last month's announcement by federal health officials that they would no longer reimburse the state for Molina's HMO services to Medi-Cal patients. Molina and state officials said Friday that they had reached a resolution "in concept" but that papers remained to be signed and details to be worked out.

At stake in the dispute is a $1.6-billion, six-year contract that Molina won in 1994 to administer one of two regional Medi-Cal managed-care plans in Riverside and San Bernardino counties. Molina stands to lose the prized contract if it cannot comply with federal requirements.

"This does preserve Molina as [the Inland Empire's] mainstream contractor," Molina spokeswoman Kassy Perry said Friday.

Universal Care of Signal Hill, one of Molina's fellow Medi-Cal managed-care subcontractors in Los Angeles County, was the first to make a merger proposal last week, but Perry said the negotiations are "not exclusive" and Molina is exploring "many options."

Sources familiar with the negotiations said the state will hold Molina to a strict deadline, and retaining the contract is not a certainty. Perry said the state extended Molina's status as a full-service contractor for "a certain period" in which the company will aggressively pursue compliance with federal law.

She said of the outcome of the negotiations: "We're thrilled."

The U.S. Health Care Financing Administration cut off its funding for Molina's services May 1, saying Molina had not abided by a key federal patient-mix rule. The state could not afford to make up the funding difference.

Medi-Cal health maintenance organizations are required by federal law to attract enough private patients to make up at least 25% of their caseloads. The requirement is intended as a rough assurance of quality, preventing programs for the poor from becoming so-called Medicaid mills that marginalize poor patients and provide inferior care.

Molina officials acknowledged that the company had less than 2% private patients, but blamed the state Department of Health Services, saying it had never applied for a three-year waiver allowing the company time to build up its commercial base. In addition, Perry said, the state misinformed the company about when it had to come into compliance.

State officials acknowledge they did not formally apply for the waiver, but said they had a verbal agreement with federal health officials that the waiver would be in place from approximately April 1994 to April 1997. Molina, they said, did not meet the deadline.

On Friday, the state Department of Health Services was tight-lipped, saying only that an agreement had been reached with Molina that will eliminate the "disruption of services to beneficiaries and [of] payments to providers." Spokesman Ken August said Molina will have a "reasonable amount of time" to meet state and federal requirements.

There is no guarantee the Health Care Financing Administration will be satisfied with the terms of the deal.

Rachel Block, director of federal Medicaid Managed Care Team, said in a May 9 letter to state Health Director S. Kimberly Belshe: "There is insufficient information in the letter of intent between [Molina] and Universal Care to determine the purpose and appropriateness of the proposed merger."

Consumer groups reacted angrily Friday to word of the proposed deal, saying it essentially violates the only measure of consumer protection in federal law for Medicaid managed care.

"It dooms people to second-class service," said Jeanne Finberg, a senior attorney with Consumers Union, publisher of Consumer Reports.

Lynn Kersey, director of Maternal and Child Health Access, a patient advocacy group in Los Angeles, said the state has shown a pattern of bending and breaking the rules.

"Milestones are laid out and they are not met and [there are] no consequences," Kersey said.

Scrambling to come up with a solution, state officials last week had offered to allow Molina to continue to serve as an outpatient health plan only, which would have meant a significant financial loss to the company and jeopardized the plan's Inland Empire contract. Molina spurned that solution.

The deal, if it goes through, is almost certain to inspire protest—and perhaps legal action—by Blue Cross of California, which scored second-highest in the bidding for the Inland Empire contract and had hoped to be named a contractor if Molina was forced out.