DHCS Responses to Stakeholder Advisory Committee Follow up Items from September 11

Follow-up Items	DHCS Response	DHCS Response
Stuart Siegel, Children's Specialty Care Coalition: Can you give us more information about measurement criteria for whether care is being coordinated adequately? Do you have a way to understand whether the person caring for a patient has the experience required for the patient?	*Bruce Lim, Division Chief, DHCS: We coordinate our efforts with DMHC so we don't duplicate. They perform the survey; we perform the Medi-Cal audit. At the entrance and exit interviews, we encourage additional information. I can get back to you on the details related to your question.* *Brooks: We do review documents that include provider adequacy and coordination of care. Perhaps the health plans with us today will comment.*	The DHCS annual medical audit, DMHC Knox-Keene survey, and the transitional surveys conducted by DMHC on behalf of DHCS through an interagency agreement contain measurement criteria to ensure that care is being coordinated. These audits and surveys all contain case management and coordination of care components. Additionally, DHCS monitors quarterly grievance and appeal reports, State Fair Hearings, and various call center reports to identify potential trends and issues. The MCOs are contractually required to provide comprehensive case management, including coordination of care services to each member, and have a procedure in place to monitor the process. These services are provided through either basic or complex case management activities based on the medical needs of the member. Basic case management services are provided by the primary care provider, in collaboration with the MCO, while complex case management services are provided by the MCO, in collaboration with the primary care provider.

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Marilyn Holle, Disability Rights CA: We see clients going to the incorrect specialist because they haven't had done adequate pre-screening. Is there anything in the audit that addresses this problem?	*Brooks: We will go back and respond to your question once we've had a chance to review all audit questions.*	Yes, health plans are contractually required to conduct an Initial Health Assessment or a Health Risk Assessment for non-SPDs and SPDs, respectively. The purpose of these assessments is to evaluate the member and use the information to develop a treatment plan. The MCO is also required to provide for standing referrals to specialists, in accordance with Health and Safety Code Section 1374.16. Health and Safety Code Section 1374.16 and the Medi-Cal boilerplate contracts require the MCO to have procedures in place for a member to receive a standing referral to a specialist if the primary care physician determines, in consultation with the specialist and MCO Medical Director or the Medical Director's designee, that a member needs continuing care from a specialist. If a treatment plan is necessary in the course of care and is approved by MCO, in consultation with the primary care physician, specialist, and member, a referral shall be made in accordance with the treatment plan. Assessments and referrals are part of the DHCS annual medical audit, DMHC Knox-Keene survey, and the transitional surveys conducted by DMHC on behalf of DHCS through an interagency agreement.
Marvin Southard, LA County Department of Mental Health: Would SUDS services under EPSDT be required to meet these timely access standards?	*Brooks* : I will follow up on this after the meeting.	SUDS would fall under the timely access requirements for mental health. These can be found at Title 28 section 1300.67.2.2 (c)(5)(E).

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Gary Passmore, CA Congress of Seniors: Do you look at language access, physical access of providers, particular equipment – what do you mean by access? *Brenda Premo, Harris Family Center for Disability and Health Policy: Do you assess whether providers have particular equipment to serve special populations, particularly people with disabilities? You have a website to allow people to file a complaint if they find they can't be served due to accessibility issues.*	*Feng: We do look for language assistance to ensure that providers are meeting the accessibility requirement. We also look at timely access, as well as geographic accessibility.* *Feng: I will have to get back to you with specifics.* *Nau: We do have an addition specific to SPD populations to cover physical access. It's required for credentialing and re-credentialing of providers.*	In May 2011, DHCS released policy letter 11-013 that requires the health plans to conduct a physical accessibility review of all primary care physician, specialist, and ancillary provider sites that serve a high volume of Seniors and Persons with Disabilities. The review is conducted through Attachment C of the Facility Site Review (FSR). The FSR is a requirement for credentialing and recredentialing, and thus must be conducted when a provider enters the MCO network and every three years thereafter, at a minimum. The physical accessibility review consist of 86 elements that cover everything from the building, parking, elevator, exam room and restroom access, to medical equipment, such as adjustable exam tables wheelchair accessible scales. The policy letter can be accessed under the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf
Gary Passmore, CA Congress of Seniors: What is the link to the joint audits, coordination and action plans?	*Brooks: We will send out the link to DHCS web site.* *Douglas: This is streamlined in response to requests.*	Audits, surveys, and the resulting corrective action plans that have been posted to the DHCS website can be found at the following link:http://www.dhcs.ca.gov/services/Pages/ManagedCareMonitoring.aspx

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Marvin Southard, LA County Department of Mental Health: An unfinished issue in this benefit is establishing the boundary of mild/moderate and serious. Even the counties are not in agreement about this. Over the next 6 months, we need to finalize this. I think we need to design the system so patients get what they need.	*Brooks: This is a very important issue. We are holding meetings to work out this issue of level of impairment. We will come out with guidance about what to do if there is a dispute about who should be providing care.* *Douglas: We will come back to a future SAC with a report out on this topic.*	DHCS currently has a draft All Plan Letter on Dispute Resolution and accompanying Mental Health and Substance Use Disorder Information Notice out for comment. We acknowledge this very important issue and are working towards finalizing this guidance.
Michelle Cabrera, Service Employees International Union: What is asked of beneficiaries in assessment surveys on care coordination and network adequacy?	*Brooks: We conduct CAPS survey that includes info on access. We will survey separately Healthy Families. We can send out the survey questions. For rural expansion, we have a survey both before and follow up to enrollment in managed care.*	The following surveys are being provided to you for your reference: CAHPS adult survey, CAHPS child survey, Rural expansion survey questions
Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: I am aware of two large plans that are allowing interns to serve mild/moderate MH because there are not enough providers and this will help with access in these plans. None of this addresses psychiatry network adequacy.	*Brooks: We did add interns to SPA with appropriate supervision. I would like to follow up with you on psychiatry issue.*	Managed Care reached out to Al Senella on the psychiatry issue. Nothing to send to SAC members
Kristen Golden Testa, The Children's Partnership/100% Campaign: Do you look at children separately for each monitoring issue, for example, reviewing the network adequacy for pediatricians for the number of children?	*Feng: We do make sure that pediatricians are included in the range of PCP, but we don't have an enrollee break-down of adults vs. children. But this is something that we could look at in the future.*	DHCS currently has the attached draft EPSDT APL circulating for comment and is working with stakeholders, advocates, and Medi-Cal managed care plans to finalize the guidance.Further, EPSDT is a component of the annual medical audit performed by the DHCS Audits and Investigations Division. Additionally, DHCS monitors quarterly grievance and appeal reports, State Fair Hearings, and various call center reports to identify potential trends and issues.

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Kristen Golden Testa, The Children's Partnership/100% Campaign: Where is EPSDT in the monitoring, considering some are in managed care and some are not?	*Brooks: We look at plans for managed care enrollment. We will be issuing a new all plan letter on EPSDT. I need to follow up with specific monitoring information.*	DHCS currently has the attached draft EPSDT APL circulating for comment and is working with stakeholders, advocates, and Medi-Cal managed care plans to finalize the guidance.Further, EPSDT is a component of the annual medical audit performed by the DHCS Audits and Investigations Division. Additionally, DHCS monitors quarterly grievance and appeal reports, State Fair Hearings, and various call center reports to identify potential trends and issues. - Sending draft EPSDT APL with this item
Bill Barcelona, CA Association of Physician Groups: Cap G groups want to integrate health homes that serve both BH and physical health. We have groups working on health homes and have some lessons to share. We need to have dialogue with the department.	*Douglas: We have an agency wide discussion of health homes as part of CalSIM. There will be a process going forward on all payers related to health homes. More to come.*	In collaboration with CalSIM, DHCS held a webinar on November 17th regarding a draft concept paper for Health Homes, and have posted the draft concept paper for feedback. Comments are due to DHCS by December 1st. The concept paper, a contact email, and other meeting materials can be found on the DHCS Health Homes webpage:http://www.dhcs.ca.gov/provgovpart/Pages/HealthHomes.aspx
Marilyn Holle, Disability Rights CA: What happens to CCS clients when they turn 21? Also those with genetic handicaps? What happens related to outcomes when they move to the adult population without coordination? I'm seeing a lack of any kind of meaningful transition for people with cystic fibrosis, sickle cell, etc.	*Brooks: We can follow up with you. We work closely with CCS on this. There is oversight that the Department can put into place.*	CCS county programs transition clients turning 21 years old to adult health care services. Clients with genetically handicapping conditions such as Hemophilia, Cystic Fibrosis, or Sickle Cell are referred to the GHPP program. Clients must submit an application form to enroll in the program. Upon enrollment, clients are referred to the appropriate GHPP-approved Special Care Center (SCC), such as the Hemophilia Treatment Center, CF SCC, etc., for comprehensive medical management and coordination of care.

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Brenda Premo, Harris Family Center for Disability and Health Policy: My comment on the renewal of 1115 waiver. I commend departments on listening and there has been a lot of progress. The plans have done a wonderful job with kids and families. The problem is readiness for SPD and Duals, a population that is 100% people with disabilities and needs with very diverse disabilities and different issues than kids and families. The state has taken huge new populations of limitations and disability. We need to look more holistically at the needs of people. We need to rethink the way we serve people with diverse disabilities and needs. I want this committee to look at things differently. Two examples: Network adequacy needs to include themachinery and whether that equipment is accessible. The state is starting to look at this now but it is late. How do we look at developmental disabilities who need guidance to navigate the system? For the renewal of 1115 waiver, this is the discussion we need to have. How can we refocus our questions of access for persons with disabilities?	*Douglas: Thank you for that challenge and it gets to our need to have venues for those conversations. Thank you to all who shared here today. Thank you to partnership with DMHC.*	DHCS released Policy Letter 11-013 in May 2011 that required the health plans to conduct a physical accessibility review of all primary care physician, specialist, and ancillary provider sites that serve a high volume of Seniors and Persons with Disabilities. The Policy Letter can be accessed under the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf
Gary Passmore, CA Congress of Seniors: Can you provide break out of who is opting out (continuity of care) demographically?	*Cantwell: Yes, we will look into it and get back to you.*	DHCS is working to assess the opt-out population and will share further information in the coming months with stakeholders.
Marilyn Holle, Disability Rights CA : I just want a clarification. When you get the continuity of care referral does that includes the lab work, CT scan if necessary, etc., so that it's all done in one place?	*Cantwell: I will follow up with you*	Duals Plan Letter 14-004 states: "The following providers are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other **ancillary services**, or carved-out services (however, continuity of services is required)." "Ancillary services" includes lab work and CT scan.

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Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Are the opt-out numbers on track with expectations? Do you have information on the reasons why?	*Cantwell: The numbers are very close to our estimates and are on track. The numbers may change in the future, as individuals begin to opt out who were enrolled. Of those who are eligible to opt out (got 90 day notice about enrollment), there are 39% of opt-outs. We will follow up to offer a clearer way to present this. We don't have the reasons for opt out.*	DHCS is working to assess the opt-out population and will share further information in the coming months with stakeholders.
Gary Passmore, CA Congress of Seniors: Can you post the ideas you receive on the waiver?	*Cantwell: Yes, I will work to see how to do this.*	Letters to submitted to the Dept. via electronic mail are all posted on the Waiver Renewal site. We update with new letters received every week or two so it's updated in batches. We also post a summary tracking sheet of the comments from letters. Meeting summaries of each workgroup will also be posted.
Marilyn Holle, Disability Rights CA: is there a flyer about getting care if you don't have a BIC card?	*Mollow: There is no flyer; it is posted on the website and we can make it available to you.*	DHCS has posted a page on "Information for Pending Applicants and Newly Enrolled Medi-Cal Members" where individuals can review the options to gain immediate care: http://www.dhcs.ca.gov/services/medi-cal/eligibility/pages/InfoPendingMedi-calApps.aspx

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Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: I want to encourage you to reconsider the decision to exclude ex parte information.	*Mollow: We can take a look. Part of the 2014 process was not having household tax information.*	For all renewals including the Pre-ACA/2014 Renewals, counties are instructed to conduct an ex parte review first. However, since this population is Pre-ACA, the ex parte review may not always provide the necessary information, such as household tax information that is necessary to complete the eligibility determination. In most cases, the ex parte review will fail and counties will need to reach out to the Medi-Cal beneficiary for more information to complete the renewal.
Marilyn Holle, Disability Rights CA: What about the SPA for amendments of LEA?	*Mollow: We will look to see if this is needed and we will follow up.*	We are not pursuing a SPA for amendments of LEA services at this time