STATE OF CALIFORNIA

MEDI-CAL SUPERIOR SYSTEMS WAIVER COMPREHENSIVE RENEWAL

October 1, 2013 – September 30, 2015

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MEDI-CAL SUPERIOR SYSTEMS WAIVER SUMMARY

I. The WAIVER PROGRAM

A. Background

Section 1903(i)(4) of the Social Security Act precludes federal funding under Medicaid, for a hospital or skilled nursing facility that does not have a utilization review plan in effect that meets the requirements set forth in section 1861(k) of the Social Security Act. Section 1903(i)(4) also provides that these requirements may be waived when a State Medicaid Agency, such as the Department of Health Care Services (DHCS), demonstrates that it has a utilization review procedure in place that is superior to the federal requirement.

In Fee-For-Service (FFS) Medi-Cal, DHCS currently operates under the Superior Systems Waiver (SSW) for the utilization review of certain acute inpatient stays. The SSW waives certain federal utilization review requirements for acute inpatient hospitalization and allows 75 percent Federal Financial Participation (FFP) reimbursement for DHCS medical consultants (skilled, state licensed medical professionals) adjudicating Treatment Authorization Requests (TARs) or providing monitoring and oversight activities.

Since 2008, California has introduced and implemented many initiatives that have resulted or will result in reducing the FFS Medi-Cal population. Below is a brief summary of those initiatives:

1. **Transition of Seniors and Persons with Disabilities (SPDs) into Managed Care**

   SPDs who reside in managed care counties were mandatorily enrolled in managed care plans during a 12 month transition process that was completed in June 2012.

2. **Expansion of Managed Care into Additional Counties**

   DHCS is transitioning full scope FFS beneficiaries in 26 of the 28 remaining rural counties to managed care. This expansion is tentatively scheduled to be completed by December 31, 2013.

3. **Implementation of Diagnosis Related Groupings (DRGs)**

   The private hospitals transitioned from the TAR requirement for acute inpatient hospital days to a payment methodology based on DRGs, effective July 1, 2013. It is an acuity-based methodology that achieves a fair and equitable distribution of Medi-Cal funds for inpatient acute care services. The DRG payment methodology will be implemented for Non-Designated Public Hospitals (NDPHs) on January 1, 2014.

4. **Implementing the Coordinated Care Initiative (CCI)**

   The CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called 'dual eligible' beneficiaries. The CCI is expected to be implemented no earlier than January 1, 2014.

Medi-Cal beneficiary data reflects that, from January 2008 through May 2013, the TARs submitted by FFS beneficiaries have decreased by more than sixty percent, due to the initiatives that DHCS implemented. The FFS population is expected to further decrease when CCI is fully implemented.

This comprehensive SSW renewal request describes FFS utilization review in California hospitals for inpatient hospital stays from October 1, 2013 to September 30, 2015.

B. California Medi-Cal Superior Systems Waiver

DHCS operates five Medi-Cal field offices located in Los Angeles, Sacramento, San Bernardino, San Diego and San Francisco. The Medi-Cal field offices are responsible for the utilization review of inpatient services within their geographic jurisdictions.

Designated Public Hospitals

Over the past two years, the acute inpatient utilization review activities for Designated Public Hospitals (DPHs) has transitioned from DHCS performing the day by day review on 100 percent of all hospital stays to having the DPHs perform their own acute inpatient utilization review using evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines. These criterion are industry standards based on a solid, scientifically valid foundation of medical evidence which improves quality and increases efficiency.

Non-Designated Public Hospitals

The Non-Designated Public Hospitals (NDPHs) will continue to have DHCS perform 100 percent of the day by day review of their TARs until January 1, 2014. At that time, they will convert to a DRG payment methodology. Initially, DHCS will determine the appropriateness of acute inpatient hospital admissions by requiring the NDPHs to submit hospital admission TARs to determine the medical necessity of the admission. Over the subsequent two years, it is anticipated that the NDPHs will transition to using standardized medical review criteria such as InterQual or Milliman Care Guidelines to determine the appropriateness of the hospital admission, much like the process for the DPHs.

Private Hospitals

On July 1, 2013, all private hospitals transitioned from billing each day of an approved acute inpatient stay to a payment methodology based on DRGs. For FFS beneficiaries

with full-scope Medi-Cal, the DRG process requires hospital admission TARs. For FFS Medi-Cal beneficiaries with restricted aid codes, the DRG process will continue to require a day by day TAR for all acute inpatient days.

Additional detail on the public and private hospital transition from the SSW can be found on page 13 in ***Section IV. Transition from the Superior Systems Waiver***.

1. Specific Superior Systems Waiver Services

As listed by hospital type in **Table 1** on page 8, the SSW covers the following services and beneficiaries whereby a 100 percent day by day review of TARs applies:

a. General Acute Care Inpatient Stay

This only applies to NDPHs until they convert to the DRG payment methodology on January 1, 2014, at which time only an admission TAR will be required, similar to the private hospitals. DPHs use InterQual or Milliman Care Guidelines in lieu of TARs. As noted below, restricted aid code beneficiaries will still require a day by day TAR.

b. Restricted Aid Code Beneficiaries

Beneficiaries in this category are only eligible to receive acute inpatient hospital services that are pregnancy or emergency related, and this restricted aid code policy cannot be programmed into the DRG algorithm or the standardized medical review criteria. Therefore, a TAR for each day of services is required for NDPHs and private hospitals for these beneficiaries to ensure that the hospital is compliant with state and federal policy.

c. Obstetrics (OB) Admissions

The guidelines for OB admissions are dependent upon many factors including, but not limited to, OB admission with delivery and non-delivery, as well as for well-babies and neonate stays. The utilization management approach to OB admissions is detailed in **Table 1.**

d. Acute Administrative Days

This applies only to NDPHs and private hospitals. Acute administrative days in private hospitals are not being paid using the DRG methodology. The logic for this lower level of criteria is not included in the DRG algorithm and, therefore, must be adjudicated outside of that process.

e. Acute Intensive Rehabilitation Services

These services are adjudicated according to Medi-Cal policy as outlined in the *Manual of Criteria for Medi-Cal Authorization (MOC).* DHCS maintains that the *MOC* holds providers to a higher level of care for acute intensive inpatient rehabilitation than the criteria contained in InterQual or Milliman Care Guidelines.

f. Hospice – Acute General Inpatient

A TAR is required every day for acute general inpatient hospice. This applies to NDPHs, DPHs and private hospitals.

The utilization review for those services that require a daily TAR exceed the Federal Utilization Review Plan requirements in the following ways:

i. 100 percent review of inpatient hospital days and length of hospital stay for acute inpatient services

The SSW requires 100 percent review of certain hospital admissions and each day of the hospitalization for acute inpatient stays. TAR admission requests are submitted, and the review is based on a determination of "medical necessity," including appropriate level of care and length of stay. Each TAR must contain all relevant information about the patient's condition, planned course of treatment, and expected date of discharge**.**

In contrast, the Federal Utilization Review Plan allows utilization review activities to be conducted on a sample or other basis, either by an internal hospital committee or an external committee established by the local medical society. A 100 percent review done by independent consultants is superior to a review using a sampling methodology chosen by the provider.

ii. The use of independent medical consultants instead of hospital utilization review committees to conduct reviews

Since the inception of the SSW, California has exclusively utilized State-employed professional medical consultants to adjudicate TARs for Medi-Cal inpatient services. These medical consultants are licensed physicians and nurses.

The Federal Utilization Review Plan allows utilization review to be performed by committees or groups or designated individuals who are employed by the hospital that is the subject of the utilization review. California's system is superior because of its exclusive reliance on State-employed medical professionals who are completely independent of the subject hospitals.

iii. Authorization of services includes the use of professional judgment

When reviewing acute inpatient hospitalizations for medical necessity, DHCS medical consultants follow State and Federal requirements for inpatient services, applying both their extensive knowledge of medicine and the specifications of the *MOC* published by DHCS in January 1982, last revised April 2, 2012, and incorporated by reference in Title 22, California Code of Regulations, section 51003(e). *(*http://www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf).

Because medical consultants have the opportunity to review medical records from a wide variety of hospitals, they are aware of the local and regional practice patterns in the area served by the field office. They collaborate with consultants from other field offices and are familiar with statewide practice patterns. They are active in continuing medical education and in professional societies and are knowledgeable about national practice norms, standards of practice and evidence based research. The consultants draw upon all these rich levels of experience when they determine the medical necessity of inpatient services on TARs submitted to DHCS.

In contrast to the local hospital criteria permitted under the Federal Utilization Review Plan, the SSW is superior in its reliance upon statewide written criteria and a broad spectrum of professional judgment for TAR adjudication. Established written criteria, uniformly applied, helps ensure statewide consistency in TAR decision-making and delivery of client benefits.

2. Grievances

a. Provider TAR Appeals

Pursuant to California Code of Regulations, Title 22, section 51003.1, a provider may submit an appeal if a TAR is modified or denied. The Appeals and Litigation Section at DHCS headquarters is charged with the statewide responsibility for objectively adjudicating all appeals for all TAR types, including the hospital TARs described in this SSW. This staff also is responsible for the review and processing of TAR-related litigation against DHCS. The Appeals and Litigation Section is staffed with medical consultants (many of whom have field office experience) to review, analyze and uphold or overturn TAR determinations made in the field offices. In addition, they assist in identifying quality assurance issues by statewide tracking and trending of various data elements.

b. Beneficiary Fair Hearings

Medi-Cal applicants and Medi-Cal beneficiaries have the right to a fair hearing if dissatisfied with any action, or failure to act, of the county department with respect to their eligibility, certification, and amount of liability; or with any action of DHCS with respect to the scope and duration of health care services.

The Federal Utilization Review Plan does not specify a structured appeals process and allows reconsideration of adjudication decisions by the same group and/or individual that modified or denied the original request. California's system is superior because of the formal structure of the appeals process for providers and fair hearing process for beneficiaries. Provider appeals are reviewed by State physicians and nurses independent of those making the original TAR decisions in the local field offices. Beneficiary fair hearings are conducted by Administrative Law Judges employed by California's Department of Social Services.

TABLE 1

DHCS Acute Inpatient Hospital Utilization Management

October 2013

Type of Stay	DHCS UTILIZATION MANAGEMENT APPROACH		
	Current Non-Designated Public Hospital TARs	Designated Public Hospital Oversight/TARs	Private Hospital DRG TARs
General Acute Care – Full Scope			
General acute care inpatient stay	TAR every day	Review statistically valid sample	TAR admission only
General Acute Care- Restricted Aid Codes			
General acute care inpatient stay	TAR every day, including review to ensure all services are emergency services.	Focused Review – review statistically valid sample *	No change; TAR every day, including review to ensure all services are emergency services.
Obstetrics (OB) with Delivery – Full Scope or Restricted			
OB admission with delivery	No TAR required	No TAR required	No TAR required
OB prolonged stays - vaginal greater than 2 days; C-section greater than 4 days	TAR days outside of TAR-free days	Review statistically valid sample	No TAR required
Obstetrics (OB) non-delivery			
OB admission non-delivery – full scope	TAR every day	Review statistically valid sample	TAR admission only
OB admission non-delivery - restricted aid codes	TAR every day	Focused Review – review statistically valid sample *	TAR every day
Other			
Well-baby stays admission - full scope and restricted aid codes (maternal aid codes may be used)	Not applicable – well-baby (newborns) were billed on the mother's claim. TAR every day for extra days.	No TAR required	No TAR required
Neonate (sick-baby) stays admission – full scope and restricted aid codes (maternal aid codes may be used)	TAR every day	Review statistically valid sample	TAR admission only
Administrative days	TAR every day	Focused Review – review statistically valid sample *	TAR every day
Rehabilitation stays - Acute Intensive Inpatient Rehab (AIIR)	TAR every day	TAR every day	TAR every day
Hospice – Acute General Inpatient	TAR every day	TAR every day	TAR every day

* ***Focused Review – review statistically valid sample*** refers to a statistically valid sampling from the specific category for each focused review (i.e., administrative days, restricted aid codes, etc.)

II. QUALITY ASSURANCE AND PROGRAM INTEGRITY

A critical component of the SSW, and utilization management in general, is quality assurance and program integrity. For this reason, DHCS Utilization Management Division (UMD) established the TAR Quality Assurance Section. Staff in this section are primarily responsible for the following: (a) oversight and monitoring of the designated public hospital program for consistency of application of the Medi-Cal specific policies and appropriateness of services; (b) ensuring the uniformity and standardization of TAR adjudication and DPH chart reviews among the field offices; (c) monitoring the utilization review system to determine potential issues that need policy resolution and/or procedural re-engineering; and (d) implementing methods of automation to further ensure efficiency and effectiveness of California's Medi-Cal utilization review activities.

A. Uniformity and Standardization

Uniformity and standardization are the cornerstones of the utilization review process. To the extent possible, all policies are contained in written documents. This ensures that DHCS medical consultants have a uniform reference for adjudicating TARs as well as performing oversight at the designated public hospitals, and providers understand the criteria that are used in evaluating their TARs. To the extent this is achieved, the number of TAR adjudication variances decrease over time.

The Quality Assurance Section is staffed with a physician, nurses, and analytical and research staff to support activities to identify variability among adjudication decisions so that actions can be taken to achieve greater consistency. This function is important as it assists in maintaining the uniformity and standardization that is critical to California's utilization review system.

The *MOC* is used to maintain consistent TAR adjudication guidelines for DHCS physician medical consultants in adjudicating acute rehabilitation TARs as well as rendering professional opinions. Medi-Cal Field Offices conduct monthly staff meetings and training sessions to reinforce existing guidelines and learn about new issues. The medical consultants provide on-the-job training to the Nurse Evaluators as they encounter issues with TAR adjudication. These same medical consultants also identify potential areas of remedial training needed for all staff and identify individual staff that may need additional training. DHCS Senior Medical Consultants in the Benefits Division create policy by researching recent publications, studies and standards of practice to stay current on new processes, as well as current practices and evidence based standardized medical review criteria.

Another source of knowledge used extensively by Nurse Evaluators and Medical Consultants is the UMD Desk Reference. The Desk Reference is intranet-based, and contains in-service trainings and guidance on issues that require clarification, or when new policies or trends emerge. The value of the Desk Reference is that it assists in standardizing the processes used in the various field offices for adjudicating TARs.

All UMD Nurse Evaluators and Medical Consultants have online access to State and Federal regulations and utilize their clinical expertise and professional judgment to render

TAR and DPH decisions. The Medical Consultants are uniquely positioned to identify trends, analyze situations, receive departmental policy information and provide early intervention and technical assistance to providers. The consultants proactively interact with the provider community for ongoing TAR adjudication training.

The Medi-Cal fiscal intermediary also provides quarterly training sessions for providers at several locations throughout the State. The basic training covers how to request a TAR and how to bill the program. There are advanced training sessions that cover more complex issues such as Medicare crossover claims and problems with other health care coverage.

B. Monitoring Utilization Controls

Monitoring Medi-Cal's acute inpatient FFS utilization review system is accomplished in the following ways:

a. Analysis of TAR data generated by the Quality Assurance Section; and

b. Field Office Consultant TAR decision monitoring by physician and nurse medical consultants located at UMD Headquarters.

1. TAR Data

One of the key components of monitoring utilization management is the review and analysis of TAR data to discern patterns of adjudication that change in an unexpected manner over time.

The Medi-Cal TAR approval rate has fluctuated over the past eight years, but has remained relatively consistent recently. UMD's TAR statistics, as shown in the table below, for the period of Calendar Years 2005 through 2012 indicate an upward trend in approval rates, with a leveling off in the last few years. DHCS believes this is, in part, a function of providers' clearer understanding of the requirements of medical necessity.

Acute Inpatient Hospital TAR Approval Rate	
2005	70%
2006	77%
2007	79%
2008	83%
2009	78%
2010	82%
2011	83%
2012	82%

Other types of analyses routinely performed to ensure program integrity include:

- Reports regularly generated to monitor TAR volume and processing timeframes by TAR type in each field office, as well as approval, denial, deferral and modification rates for all TARs.
- Fair Hearings, appeals and litigation decisions monitored to identify areas in need of policy clarification.

2. Field Office Consultant TAR Decision Monitoring

To ensure that admissions are appropriate, length-of-stay and level-of-care are consistent with a patient's medical needs, continuing care is medically necessary, and DPH reviews are consistent and appropriate, the activities of field office medical consultants are monitored by senior physicians and nurse consultants, and other professional staff from the field offices and Headquarters. The physician medical consultants include board-certified specialists in various medical specialties with extensive experience in private practice.

Routine monitoring functions can be performed in Headquarters. Medical consultants use reports to assist in monitoring utilization trends to identify areas amenable to early intervention and problem resolution.

C. Application of Technology

As technology has advanced, the potential continues to increase for automating the TAR process, DHCS continues to transition to electronic chart review, also known as "virtual on-sites," which are electronic record reviews in which State nurses review medical records remotely by accessing the hospital's system from the field office. A virtual on-site eliminates the need for medical consultants to go out to the hospital to review charts on-site. Moreover, more providers are submitting their TARs electronically (e-TARs). In addition to realizing the advantages that virtual on-sites present, submitting the TARs via e-TAR eliminates the need for each medical consultant to establish and maintain usernames and passwords at each hospital.

III. JUSTIFICATION AND COST BENEFIT

Justification of the Waiver Program as a Superior System

California's Medi-Cal SSW program constitutes a Superior System for the following reasons:

- As the acute inpatient hospital stay is one of the more costly Medi-Cal services, there is significant value in conducting a 100 percent review of these TARs for specific TAR types. Licensed physicians review the most complex TARs (e.g., acute rehabilitation, etc.), while Nurse Evaluators review all other TAR types. TARs not recommended for full approval by a Nurse Evaluator are further reviewed by a licensed physician before issuing the adjudication decision.

- The SSW utilizes State Nurse Evaluators and Medical Consultants to adjudicate certain acute inpatient TARs; by definition, these State staff are unbiased, independent decision makers. It is more appropriate for medical consultants who are independent from a specific hospital review committee to make decisions regarding medically necessary hospital stays.

- The SSW utilizes written criteria for making adjudication decisions in conjunction with State and Federal requirements for inpatient services, extensive research of standards of practice and evidence based review criteria, and the professional judgment of field office medical consultants. Some of these documents include the *Manual of Criteria for Medi-Cal Authorization*, as well as State statute and regulations.

- By incorporating formal appeal processes handled by State staff, the SSW provides a second independent review to ensure accurate TAR adjudications. The overall accuracy of those adjudications is demonstrated by the fact that in 2012, less than 5 percent of the acute inpatient hospital days that were denied and subsequently appealed were ultimately approved through the appeals process. Moreover, Medi-Cal's appeals process offers a relatively inexpensive administrative remedy in order to avoid the need for costly litigation.

IV. Transition from the Superior Systems Waiver

Although 100 percent day by day review helps control unnecessary and excessive use of acute inpatient services, it is also resource intensive, requiring numerous clinical staff located throughout the state to review and adjudicate TARs. To increase efficiency and effectiveness while still ensuring hospital inpatient stays are billed appropriately, DHCS has transitioned or will transition most acute inpatient days away from 100 percent day by day review.

A. Transition of Private Hospitals from 100 percent day by day TAR requirement for most acute inpatient hospital stays

On July 1, 2013, all private hospitals transitioned from billing each day of an approved stay to a payment methodology based DRGs as mandated by Welfare & Institutions Code, section 14105.28. DRG is an acuity-based methodology that achieves a fair and equitable distribution of Medi-Cal funds for inpatient acute care services.

For FFS beneficiaries with full-scope Medi-Cal, the DRG process requires hospital admission TARs, which will determine the medical necessity of a hospital admission. This is significantly less resource intensive than the current process of reviewing each day of an inpatient stay for medical necessity for acute level of care. It is estimated that hospital admission TARs will, on average, require one-third of the time to adjudicate as a day by day review.

For FFS Medi-Cal beneficiaries with restricted aid codes, the DRG process will continue to require a day by day TAR for all acute inpatient days, as beneficiaries in this category are only eligible to receive acute inpatient hospital services that are pregnancy or emergency related, and this restricted aid code policy cannot be programmed in the DRG algorithm. Therefore, it is necessary to continue to review each day of services for these beneficiaries to ensure that the hospital is compliant with state and federal policy.

Regardless of aid code or length of stay, no TAR will be required for obstetric admissions that result in a delivery or for a normal newborn. An admission TAR will be required for sick newborns. Treatment authorization guidelines for hospitals reimbursed by DRGs are outlined in ***Table 1***.

Beginning on October 1, 2015 or sooner, DHCS will begin working with all private hospitals to transition away from the hospital admission TAR process to using evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines to determine medical necessity for hospital admissions. This process is projected to take approximately two years.

Per Welfare and Institutions Code, section 14105.28 subdivision (b)(1)(A)(i), designated public hospitals, psychiatric hospitals, and rehabilitation hospitals are excluded from the DRG payment methodology. Further, subdivision (b)(1)(B) states that DRG based payments shall apply to all inpatient hospital claims, except

claims for 1) psychiatric inpatient days; 2) rehabilitation inpatient days; 3) managed care inpatient days; and 4) swing bed stays for long-term care services. Psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay is in a distinct-part unit of a general acute care hospital or other hospital categorization.

B. Transition of Public Hospitals from 100 percent day by day TAR requirement for most acute inpatient hospital stays

Designated Public Hospitals

DHCS is working with the DPHs to convert them from the TAR process to performing their own utilization review of acute inpatient stays using evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines.

DHCS conducted a pilot program from 2009 to 2011 with two DPHs to evaluate their review criteria (both hospitals used InterQual) in comparison to reviews performed by Medi-Cal consultants. The InterQual and Medi-Cal reviews were very similar in determining medical necessity. As a result, DHCS is implementing a program whereby all DPHs are converting to the use of an evidence-based standardized medical review criteria, with State medical consultants performing independent oversight to ensure federal funds are claimed appropriately.

DPH services in which InterQual or Milliman Care Guidelines criteria shall be used are specified in ***Table 1***. Psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay is in a distinct-part unit of a general acute care hospital or other hospital categorization. Psychiatric and rehabilitation hospitals are specifically excluded.

As of June 1, 2013, 19 of 21 DPHs have completed the aforementioned transition. The remaining two (2) hospitals have not demonstrated preparedness to transition. DHCS will continue to work with these hospitals to transition them into the program as soon as they are determined by DHCS to be ready.

The new process will be superior to the minimum federal requirements for utilization review purposes because it will involve reviewing a statistically valid sample of medical records and augmenting the sample with focused reviews to ensure that specific Medi-Cal policy are applied appropriately. For example, a focused review may consist of a sample of medical records for beneficiaries with restricted aid codes to ensure that the services for which the hospital submitted claims are only for medically necessary emergency services under the State and Federal definition. Further, it will allow the UMD medical review staff who currently review TARs to instead provide oversight and training to hospital staff. In compliance with federal requirements, the utilization review will be performed by the hospital. However, it will be based on evidence-based review criteria that are widely accepted within the provider and payer communities.

Due to changes in medical practice, evidence based standardized medical review criteria software (i.e., InterQual and Milliman Care Guidelines) is evolving, and there are updates periodically. To ensure uniformity and standardization, DHCS will require that DPHs use the most current version available.

This new process will not eliminate the ability to appeal for denied inpatient stays at DPHs. As noted on page 7, if the beneficiary contests a denied day, the beneficiary has the right to file for a fair hearing through DHCS.

If a hospital is deemed non-compliant with the requirements that govern the DPH utilization management process, DHCS may terminate the facility's participation in the Program, and require another method of utilization review.

Since this program replaced the day by day review of inpatient hospital stays with another method of oversight and monitoring of the utilization process, the DPH utilization management process remains an integral part of the SSW.

Non-Designated Public Hospitals

For the 46 NDPHs, DHCS anticipates implementing on January 1, 2014, the DRG payment methodology and DRG authorization process, similar to the private hospitals' transition on July 1, 2013. DHCS anticipates that, starting January 1, 2014, it will begin working with the NDPHs to transition away from the hospital admission TAR process to using evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines to determine medical necessity for hospital admissions. This process is projected to take approximately two years.

DHCS has developed a schedule on the next page to reflect estimated times when key activities in the NDPH transition will occur. This process is similar to the process that was used for the DPH transition, while taking into consideration and incorporating those characteristics unique to NDPHs, such as their low volume of FFS Medi-Cal beneficiaries and potential inexperience with Medi-Cal policies.

TENTATIVE SCHEDULE FOR
TRANSITIONING NON-DESIGNATED PUBLIC HOSPITALS
TO INTERQUAL/MILLIMAN CARE GUIDELINES

Activity	Timeframe
Update NDPH Hospital List ○ Contact info ○ CFO and Hospital (Case Manager) Contact	**July – September 2013**
Create Communication / Stakeholder Engagement Plan ○ Engage District Hospital Leadership Forum (NDPH association) ○ Develop a Recurring Stakeholder Meeting/Teleconference ▪ Determine who is a stakeholder ▪ Stakeholder Meeting Schedule ○ Provider Outreach ▪ Web/provider bulletins and manual updates	**July 2013 and ongoing**
Research/Gather Data ○ Obtain current monthly Medi-Cal Fee-For-Service (FFS) admission volume ○ Survey Non-Designated Public Hospitals (NDPHs) to find out who has InterQual/Milliman Care Guidelines ○ Develop temporary alternative if NDPH does not have InterQual or Milliman Care Guidelines	**September – October 2013**
Create Internal Steering Committee ○ UMD/SNFD/CA-MMIS/A&I ▪ Determine division responsibility by task	**September – October 2013**
Develop Oversight / Monitoring Plan ○ Using the current DPH process as a base, tailor NDPH oversight and monitoring to meet the needs of NDPHs and UMD. ▪ Determine variance threshold based on smaller volume ▪ Determine compliance review schedule (quarterly/semi-annually/annually) ▪ Determine compliance review modality (on-site, virtual, etc.) ○ Modify *Memorandum of Understanding* with A&I to include NDPHs	**January – June 2014**
Develop / Conduct Provider Training ○ Develop training curriculum and schedule ○ Create Webinars ○ Train NDPHs	**April 2014 and ongoing**
Convert NDPH Utilization Management to InterQual/Milliman Care Guidelines	**July 1, 2014 – June 30, 2016**

C. Transition of Seniors and Persons with Disabilities into Managed Care

Seniors and Persons with Disabilities who reside in managed care counties were mandatorily enrolled in managed care plans during a 12 month transition process beginning in June 2011. Although this transition has been completed, it is important to note, as it resulted in a significant number of FFS beneficiaries being transferred out of the TAR process. Moreover, DHCS carved out of this requirement the following groups :

- California Children's Services
- Intermediate Care Facilities for the Developmentally Disabled
- Dual Eligibles
- Foster Children
- Beneficiaries with a share of cost

Utilization management for acute inpatient hospital stays for these groups will be incorporated into the existing structure. Claims for those beneficiaries that receive services in a hospital that is using the DRG methodology will be paid according to that methodology. Claims for those beneficiaries that receive services in a DPH will be paid at cost.

D. Expansion of Managed Care

DHCS continues to increase the number of counties in which Medi-Cal is offered through Managed Care Plans. To this end DHCS is transitioning full scope FFS beneficiaries in 26 of the 28 remaining rural counties to managed care. This expansion is tentatively scheduled to be completed by December 31, 2013.

E. Coordinated Care Initiative

The Coordinated Care Initiative (CCI) is designed to coordinate care for "dual eligibiles" or persons eligible for both Medicare and Medi-Cal who are often cronically ill and vulnerable. CCI is currently in the process of fully integrating the delivery of medical, behavioral, and long-term care services to this population, with an expected implementation date of January 1, 2014.

V. Tribal Notification

DHCS sought input from CMS on July 10, 2013, regarding whether the Superior Systems Waiver renewal would have a direct impact or directly affect Indian Health Programs or Urban Indian Organizations, thereby requiring tribal notification in accordance with SPA 12-022. In an email correspondence from CMS dated July 11, 2013, CMS indicated that tribal notification for the Superior System Waiver renewal was not necessary.

VI. EXEMPTIONS TO THE WAIVER PROGRAM

Exemptions

The following are exemptions to the Medi-Cal SSW described in Sections I through III (above).

A. Indian Health Services

Indian Health Inpatient Facilities in the border territory of Phoenix are excluded from the Medi-Cal SSW because utilization review is conducted according to Title 42, Code of Federal Regulations, Part 456, Subpart C, utilizing the Federal method. TARs are not submitted to the Medi-Cal Field Offices for adjudication. The excluded inpatient facilities are Phoenix Indian Medical Center, Fort Yuma Hospital, and Parker Hospital.

B. Alameda County Medical Center

Alameda County Medical Center (ACMC) is specifically excluded from this Waiver, as cited in Welfare and Institutions Code, sections 14133.5 and 14133.51, because the requirements of Title XVIII of the Social Security Act are met. In February 2008, ACMC fully implemented InterQual for the determination of medical necessity for acute inpatient hospital stays.

C. TAR-Free Obstetrical Acute Care

Pursuant to Welfare and Institutions Code, section 14132.42, inpatient hospital care for a normal vaginal or caesarean section delivery cannot be restricted to a time period of less than 48 hours or 96 hours, respectively. Under this legislation, routine deliveries in an acute inpatient care hospital do not require a TAR to be submitted to Medi-Cal for review of medical necessity for the first two days after a vaginal delivery and the first four days after a caesarean section.

D. Psychiatric Services

These services are approved by the counties, and are outside of this waiver.

Attachment I

MEDI-CAL SUPERIOR SYSTEMS WAIVER SUMMARY

Type of Waiver:	1903(i)(4)
Proposed Renewal Term:	October 1, 2013 through September 30, 2015
Program Services Area:	Statewide
Department of Health Care Services (DHCS) Contact:	Doug Robins, Chief, Utilization Management Division

Purpose of Waiver:

The purpose of the Medi-Cal Superior Systems Waiver (SSW) is to control unnecessary and excessive use of Fee-for-Service (FFS) acute inpatient services. The waiver ensures 100 percent review of certain acute inpatient hospital days. In addition, the waiver ensures TAR adjudication using statewide standardized written criteria.

Background:

Section 1903(i)(4) of the Social Security Act provides that to participate in Medicaid, a hospital or skilled nursing facility must have a Utilization Review Plan in effect that meets the requirements set forth in section 1861(k) of the Social Security Act. Section 1903(i)(4) also provides that the requirements can be waived when a State Medicaid Agency shows that it has utilization review procedures in place that are superior to the Federal requirements.

California Medi-Cal Superior Systems Waiver:

The SSW exceeds the Federal Utilization Review Plan in the following areas:

1. <u>Sampling Method for Utilization Review</u>

   The SSW requires 100 percent review of certain hospitalizations for certain types of acute inpatient services. For Designated Public Hospitals (DPHs), the SSW requires 100 percent utilization review using a standardized medical review criteria. In contrast, the Federal Utilization Review Plan allows committees or groups performing utilization review to do this on a sampling or other basis using a sampling methodology chosen by the provider.

2. Utilization Reviews

The SSW requires day by day TARs to be reviewed, and Public Hospital Program monitoring to be performed by independent Nurse Evaluators and physician Medical Consultants employed by State Medi-Cal Field Offices. The Federal Utilization Review Plan requires a utilization review committee selected by the hospital to review TARs.

3. Authorization of Services includes Professional Judgment

The SSW requires all State-employed Nurse Evaluators and Medical Consultants to utilize statewide written criteria, professional judgment, and review of medical literature, along with consultation with other physicians, to ensure that medical decisions are consistently and uniformly applied. In contrast, the Federal Utilization Review Plan requires the local hospital utilization review committee to develop hospital-specific, written criteria to define their own utilization review guidelines.

4. Formal Appeal Process

The formal appeal process that accompanies the State adjudication of the reviews allows due process for those providers and beneficiaries denied authorizations for acute inpatient hospital days. These formal processes incorporate an independent review of denials through either State headquarters Medical Consultants or Administrative Law Judges, depending on whether the appeal is requested by a provider or a beneficiary.

Tribal Notification:

DHCS sought input from CMS on July 10, 2013, regarding whether the SSW renewal would have a direct impact or directly affect Indian Health Programs or Urban Indian Organizations, thereby requiring tribal notification in accordance with SPA 12-022. In an email correspondence from CMS dated July 11, 2013, CMS informed DHCS that that tribal notification for the SSW renewal was not necessary.

Medi-Cal Superior Systems Waiver Exemptions:

1. Indian Health Services

- The SSW excludes Indian Health Inpatient Facilities in the Phoenix border area because the utilization review is conducted in accordance with Title 42, Code of Federal Regulations, Part 456, Subpart C, utilizing the Federal method.
- The excluded inpatient facilities are: Phoenix Indian Medical Center and Parker Hospital.
- TARs are not submitted to DHCS Medi-Cal Field Offices for adjudication.

2. Alameda County Medical Center

Alameda County Medical Center (ACMC) is specifically excluded from this Waiver, as cited in Welfare and Institutions Code, sections 14133.5 and 14133.51, because the requirements of Title XVIII of the Social Security Act are met. In February 2008, ACMC fully implemented InterQual for the determination of medical necessity for acute inpatient hospital stays.

3. TAR-Free Obstetrical Acute Care

Pursuant to Welfare and Institutions Code, section 14132.42, routine deliveries in an acute inpatient care hospital do not require a TAR to be submitted to Medi-Cal for review of medical necessity for the first two days after a vaginal delivery and the first four days after a caesarean section.

4. Psychiatric Services

These services are approved by the counties, and are outside of this waiver.

Public Hospitals and TAR Requirement:

Public hospitals are excluded from the TAR requirement when they transition into using evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines, to assess medical necessity. As of June 1, 2013, 19 of 21 DPHs have completed the transition. The remaining two hospitals have not demonstrated preparedness to transition. DHCS will continue to work with these hospitals to transition them into the program when they have demonstrated readiness.

DHCS anticipates that, beginning January 1, 2014, all 46 Non-Designated Public Hospitals (NDPHs) will be placed in the DRG payment methodology and DRG authorization process. Additionally, beginning in July 2014, DHCS anticipates the first of the 46 NDPHs will transition to evidence-based standardized medical review criteria to determine medical necessity for their hospital admissions. This process is projected to take approximately two years.