Requested Agenda Item

**Required Benefits for Children Insured Under Managed Care**

What is the state’s ability and framework is to monitor and document EPSDT services that should be provided in Medi-Cal managed care. Does the state think managed care contracts are specific enough? Could we please get the wording for the specific language? A new informational bulletin (PDF) from the Centers for Medicare & Medicaid Services (CMS) explains services that must be included under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children insured through managed care. The bulletin notes that states should include enough specificity in managed care plan contracts to avoid confusion about what the EPSDT benefit includes and what entity is responsible for delivering it, and sets forth three specific ways that states can ensure such specificity.

**Response:**

DHCS conducts a robust monitoring process of all Medi-Cal services (including EPSDT services) through utilization of audits and investigations, review of grievances and appeals, state fair hearings, and independent medical reviews in addition to a number of other monitoring and data collection efforts. Requirements outlined in DHCS contracts, in addition to language from All Plan Letter (APL) 14-017, give detailed explanations of EPSDT services that Medi-Cal managed care health plans (MCPs) are required to offer, which aligns with the CMS (Centers for Medicare and Medicaid Services) informational bulletin recommendations. Please see APL 14-017 for more information. [http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf)

**MCP’s Criteria for Assignment to Case Management**

Could DHCS follow up with plans about their criteria for assignment to case management? It would be good to have all of them on paper and able to be accessed, even if not standard. This is especially true in light of the Whole Person Care project and the use of the term case management for this high-risk population. It would be good to know what is considered the health plans’ work and what the difference is with what Whole Person Care will provide.

**Response:**

The MCPs are responsible for the provision of both basic and complex case management. MCPs are responsible for creating a process to identify beneficiaries who might require complex case management versus basic case management services, as well as identifying newly enrolled beneficiaries who may need expedited services. Per DHCS’s contracts with the MCPs, that process includes identifying beneficiaries who may benefit from complex case management services using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals. Policy Letter (PL) 14-005 and Dual Plan Letter (DPL) 15-005 outline additional health risk stratification requirements for seniors and persons with disabilities (SPDs) as well as beneficiaries dually enrolled in Medicare and Medi-Cal. In addition, PL 14-005 and DPL 15-005 requires MCPs to provide a health risk assessment (HRA) survey to all dual beneficiaries within 45 calendar days of enrollment, and to all SPDs identified as higher risk (based on HIF/MET data) within 45 calendar days of enrollment. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c) (11) to (13) and DHCS Policy Letter 14-005. Basic case management services are provided by the Primary Care Physician (PCP); however, complex case management services include a collaboration between the PCP and the MCP. Details about basic and complex case management services can be found in the contract under Case Management and Coordination of Care (Exhibit A, Attachment 11).
### Requested Agenda Item

#### Data on COC for MER Denials (APL 15-001)
We would like to see the data that DHCS collects from plans on COC requests for members who have denied MERs as outlined in APL 15-001. That data is currently not reported on the performance dashboard, and based on our experience with clients who have MER denials, we typically have to contact the plan to initiate the request so we are unsure that this automatic COC process is happening.

**Response:**
The MCPs submit quarterly MER Denial Continuity of Care (COC) reports to DHCS. The MER reports are used to verify that COC has been initiated for beneficiaries whose MER was denied. MCPs are required to provide the outcome for each COC request. At the end of each reporting quarter, DHCS reviews the plan data to validate all the MER denials utilizing weekly files from Health Care Options, DHCS’ enrollment broker. DHCS validates the MCP reporting by analyzing results and monitoring trends to ensure MCP compliance with COC requirements as outlined in APL 15-001. DHCS is not able to report data at this time.

#### Pending Enrollment Status

1) Please provide an update on plan enrollment. We are seeing issues both when someone moves to a new county (after an Inter County Transfer (ICT)), and when someone is terminated from Medi-Cal (often incorrectly) for a short period of time. What is DHCS doing to ensure that beneficiaries can quickly enroll or re-enroll in a plan when they need care?

2) I note on the Stakeholder list that there will be a written response. I’m presuming that MMCD will email that with the agenda and other items for March 9. I would respectfully ask that we still make this an agenda item. It would be good to hear from plans about this issue.

**Response:**
Senate Bill 1339 will allow DHCS to assist in the manner the Medi-Cal ICT’s are handled. Affected beneficiaries will need to call the Office of the Ombudsman and DHCS can help with their immediate needs described in the bill. There have also been specific situations where people are losing Medi-Cal and should be regaining it with a MCP within 90 days and this not occurring. Research has been done and some issues at the county levels have been found and corrected. In addition, previous issues involving those beneficiaries that are active Medi-Cal and pending a plan enrollment longer than the expected periods of time have seen an improvement since the release of a Provider Bulletin and communications. Lastly, DHCS will assuredly continue to address other specific pending enrollment issues as requested.

#### SB 964
SB 964/timely access reporting for MY 2015: overview and summary of results from Medi-Cal managed care plans/lines of business

**Response:**
Please refer to DMHC for all questions related to SB 964.
### Requested Agenda Item

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<th><strong>Ombudsman Phone System Update</strong></th>
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<td>Update on Office of the Ombudsman phone system, including data on calls received, wait times, resolution of complaints, etc.</td>
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**Response:**
MCOD management provides the available Office of the Ombudsman data as part of the Stakeholder Advisory meetings.