



## Medi-Cal Managed Care Advisory Group Written Responses to Stakeholder Proposed Agenda Items for June 9, 2016 Meeting

### Stakeholder Proposed Agenda Item and Written Response

#### **Reimbursement for Properly Supervised Registered Interns**

CAMFT has received word from its pre-licensee members, as well as our licensed members who are also supervisors, that the health plans are refusing to reimburse for Medi-Cal services being provided by properly supervised Registered Interns. Since these providers are acting in accordance with SPA 14-012, the health plans should be granting client's access to these providers. By refusing to pay for these services, however, the health plans are creating a disincentive to hire Registered Interns which is contrary to the intent of the SPA.

#### **Response:**

SPA 14-012 allows for Licensed Marriage and Family Therapists (MFT) and MFT Interns to provide psychology services, which is separate from BHT services. Licensed MFTs are listed in the State Plan as BHT providers per SPA 14-026. However, MFT Interns are not eligible under the state plan to be reimbursed for BHT services.

#### **Foster Care Population in Managed Care**

Stakeholder requested that DHCS have a dedicated person or staff that is familiar with the foster care population. In addition, the stakeholder stated that there are several MCPs that currently provide varying levels of support or case management. We request that DHCS begin the process to provide health care data on the Managed Care Performance Dashboard for the foster and foster adopt aid codes. Also, bring interested parties on the Managed Care Advisory Group to work with state staff on the details of the metrics. Finally, have one of the plans that are currently providing support to foster youth and their foster parents to briefly discuss how this process works in their Plan and the benefits it provides to their foster care population.

#### **Response:**

DHCS will discuss these requests and issues at the next Managed Care Advisory Group. We will also host a panel discussion regarding the foster care population with selected MCPs.

#### **Managed Care Contracting and Procurement Schedule**

When is the end date for current contracts? When will you start the next procurement process, and what is the process for stakeholder engagement? Can you also include details on where/how to locate this information, e.g. submit written request; online posting etc.?

#### **Response:**

Current contract expirations vary by model type. Upon expiration of contracts, new procurement will not be automatic and is contingent on multiple factors. Stakeholder engagement is not part of the procurement process. The procurement process is managed through the Office of Medi-Cal Procurement (OMCP). OMCP will generate official releases for new procurement options, and provide more information on its [webpage](#).



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#### **Reviewing and Monitoring the Rates that MCPs are Paying Providers**

Please describe the role DHCS plays, if any, in reviewing and monitoring the rates that its contacted plans are paying network providers to provide covered services.

**Response:**

With limited exception, MCPs independently negotiate reimbursement rates with their contracted providers. This discretion is tempered by the requirement that MCPs must maintain an adequate network of contracted providers sufficient to timely provide medically necessary services to their assigned beneficiaries. So the plan's provider payments must be high enough to maintain an appropriate network. MCPs are statutorily required to timely reimburse providers claims within certain specified parameters. DHCS and DMHC review plan compliance with the applicable claims payment standards. DHCS, when appropriate investigates claims payment issues that are systemic in nature. Providers that contract with Knox-Keene licensed plans can also avail themselves to the plan's provider complaint process and/or DMHC's provider complaint process. Under certain circumstances, plans are required to pay interest on claims that are paid late.

#### **Transgender Medi-Cal Beneficiaries APL**

In LA County, there are not enough surgeons qualified to perform GRS for transgender Medi-Cal beneficiaries. How is DHCS addressing this issue with its plans?

**Response:**

Per APL 13-011, the treatment for Gender Identity Disorder (GID), also known as transgender services, is a covered Medi-Cal benefit when medical necessity has been demonstrated. Transgender services may include psychotherapy, continuous hormonal therapy, laboratory testing which monitors hormone therapy, and gender reassignment surgery (GRS) that is not cosmetic in nature. Due to the high-demand and limited number of surgeons who specialize in GRS, Medi-Cal managed care health plans (MCPs) are committed to referring beneficiaries to the most qualified, highly trained, and culturally competent providers and are continuing efforts to expand its provider network through contracting with out-of-network specialists. Prior to being consulted by a GRS specialist, beneficiaries must meet the criteria for GRS published by the World Professional Association for Transgender Health (WPATH; please see ["Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People"](#)). Many of the MCPs have established or are in the process of developing specific programs within their network to assist beneficiaries to access transgender services, including specialized case management and mental health services. DHCS is aware of the shortage of specialized surgeons that runs across all lines of business in addition to the Medi-Cal line and continues to partner with the MCPs to ensure transgender services are being provided in a timely manner.



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#### **Timely Access**

How does DHCS monitor it for COHS plans?

#### **Response**

COHS plans are audited for timely access no differently from other plan models (e.g., Two-Plan, GMC, etc.). DHCS conducts these annual audits evaluating a combination of factors for all MCPs, including, but not limited to:

- Do the MCP's policies and procedures demonstrate alignment with all timely access standards (Exhibit A, Attachment 9, Provision 3.A.2)?
- Does the EOC/Member handbook clearly display timeframes for appointments which are consistent with the timely access standards?
- Do the MCP's policies and procedures detail monitoring activities to ensure timely access to appointments (e.g., review and generation of monitoring reports at a set frequency, examination of access-related grievances, etc.)?
- Do the MCP's policies and procedures address corrective action for providers identified as non-compliant with timely access standards?
- Does the MCP track and trend access-related grievances to identify patterns of non-compliance?
- For patterns of non-compliance identified, does the MCP conduct analysis to identify root causes and discuss opportunities for improvement? Are these efforts clearly documented in meeting minutes (e.g., Access Committee, QIC, Provider Services Department, etc.)?
- Does the MCP consistently document follow-up action taken for all non-compliant providers and provide evidence of this through issuance of CAPs and re-measurement activities?

In addition to conducting document review and interviews onsite, as part of the audit process, provider offices are also randomly contacted to gauge availability of the third next available appointment for PCP, urgent care, specialist, and prenatal appointments through a verification study. As a follow-up activity to the annual audits, DHCS conducts calls to providers' offices to assess appointment availability and will communicate those results to the MCP. This process continues on a quarterly basis if the MCP fails to meet timely access requirements.



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#### **Alternative Birthing Centers in Plans Network**

Have MCPs fulfilled the need to have Alternative Birth Centers within their network, or are most contracting?

**Response:**

The guidance letter from the Centers for Medicare and Medicaid Services (CMS) ([SHO # 16-006](#)) regarding Freestanding Birthing Centers (FBC) was released on April 26, 2016. The guidance states that for Medi-Cal managed care contracts starting on or after July 1, 2017 that include Federally Qualified Health Clinics (FQHC), Regional Health Centers (RHC's), or FBC services, CMS will not approve the contracts unless each managed care plan includes at least one FQHC, one RHC, and one FBC (to the extent the state licenses or otherwise recognizes RHC and FBC providers under state law) in the provider network, where available, for the managed care health plan's contracted service area. The Medi-Cal managed care health plans (MCPs) are currently being surveyed to determine their efforts towards meeting this requirement. The MCPs are also aware and working to fulfill this requirement.

#### **Independent Physician Associations (IPA) Oversight**

Assignment of patients in IPAs, specifically pregnant women in their third trimester

**Response:**

DHCS does not have a policy regarding transfers of beneficiaries at any point during a pregnancy. DHCS delegates medical management to its contracted MCPs and monitors the MCPs in order to ensure compliance with all applicable federal and State law as well as contract requirements.

#### **Recent APLs, DPLs and PLs**

**Response:**

Handouts will be provided during Managed Care Advisory Group meetings.