STATE OF CALIFORNIA

MEDI-CAL SUPERIOR SYSTEMS WAIVER COMPREHENSIVE RENEWAL

October 1, 2015 – September 30, 2017

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Attachment 1: Medi-Cal Superior Systems Waiver Summary

I. THE WAIVER PROGRAM

A. California Medi-Cal Superior Systems Waiver

This comprehensive Superior Systems Waiver (SSW) renewal request describes Fee-For-Service (FFS) utilization management in California hospitals for inpatient hospital stays from October 1, 2015 - September 30, 2017.

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 FFS Medi-Cal, DHCS currently operates under the SSW for the utilization review of most 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 monitoring and oversight using a combination of approaches including evidence-based medical criteria, such as InterQual® and MCG (formerly Milliman Care Guidelines), and prior authorization depending on the type of acute inpatient service, the hospital type, and the characteristics of the beneficiary's health care coverage.

Since 2008, California has introduced and implemented many initiatives that have resulted in reducing the FFS Medi-Cal population. Although Managed Care is the primary health care delivery system for most Medi-Cal beneficiaries, FFS Medi-Cal remains a critical health care delivery system, as 3 million of the 12 million Medi-Cal beneficiaries receive services through FFS.

Below is a brief summary of recent initiatives that impacted FFS Medi-Cal:

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. It is important to note that the following populations are carved out of this requirement:

- California Children's Services;
- Intermediate Care Facilities for the Developmentally Disabled;
- Dual Eligibles;
- Foster Children;
- Beneficiaries with a share of cost; and
- Beneficiaries with restricted aid codes.

2. Expansion of Managed Care into Additional Counties

DHCS has completed the transition to managed care of all full scope FFS beneficiaries in the remaining 28 rural counties. This expansion was completed November 2013.

3. Implementation of Diagnosis Related Groupings (DRGs)

The private hospitals transitioned from the daily Treatment Authorization Request (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 was 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. CCI enrollment started on April 1, 2014 for selected counties.

B. Acute Inpatient Utilization Management Approaches Included in the SSW

DHCS utilizes two approaches to acute inpatient utilization management, depending on the type of acute inpatient service, the hospital type, and the characteristics of the beneficiary's health care coverage. These approaches are:

- **Treatment Authorization Request (TAR) process,** where hospitals submit TAR requests to DHCS for review and approval prior to claiming for services; and

- **Monitoring and oversight process,** where hospitals use evidence-based standardized medical review criteria to determine medical necessity, claim for services, and then DHCS performs a compliance review**.**

Table 1 on the next page provides detail on how these two approaches are either currently utilized or proposed, and subsequent sections of this waiver detail these two approaches.

I. THE WAIVER PROGRAM, continued: TABLE 1

Type of Acute Inpatient Stay	Non-Designated Public Hospitals & Private Hospitals	Designated Public Hospitals
General Acute Care – Full Scope		
General acute care inpatient stay	Hospital UR for the admission utilizing InterQual®/MCG – DHCS to review a statistically valid claim sample * (Previously an Admit TAR)	Hospital UR for each acute day utilizing InterQual®/MCG – DHCS to review a statistically valid sample
General Acute Care- Restricted Aid Codes		
General acute care inpatient stay	TAR every day (No change from current process)	Hospital UR for each acute day utilizing InterQual®/MCG – DHCS to review a statistically valid sample
Obstetrics (OB) with Delivery – Full Scope or Restricted		
OB admission with delivery that falls within AB 1397	No TAR or InterQual®/MCG required (No change from current process)	No InterQual®/MCG required
OB prolonged stays that exceed timeframe within AB 1397 (Vaginal delivery with stay greater than 2 days; C-section delivery with stay greater than 4 days)	No TAR or InterQual®/MCG required (No change from current process)	Hospital UR utilizing InterQual®/MCG for each additional acute day outside of AB 1397
Obstetrics (OB) non-delivery		
OB admission without a delivery – Full scope aid code	Hospital UR for the admission utilizing InterQual®/MCG – DHCS to review a statistically valid claim sample * (Previously an Admit TAR)	Hospital UR for each acute day utilizing InterQual®/MCG – DHCS to review a statistically valid sample
Baby Stays		
Well baby stays - Full scope and Restricted aid code (utilizing maternal aid code)	No TAR or InterQual®/MCG required (No change from current process)	No TAR or InterQual®/MCG required, as per AB 1397
Neonate (sick baby) stays – Full scope and Restricted aid code (utilizing maternal aid code)	Hospital UR for the admission utilizing InterQual®/MCG – DHCS to review a statistically valid claim sample * (Previously an Admit TAR) (Please note that this does not apply to CCS and SARs)	Hospital UR for each acute day utilizing InterQual®/MCG – DHCS to review a statistically valid sample (This applies to days not covered by CCS)
OB admission without a delivery - Restricted aid code	TAR every day (No change from current process)	Hospital UR utilizing InterQual®/MCG and Medi-Cal pregnancy-related care coverage policy – DHCS to review a focused statistically valid sample
Other		
Administrative days	TAR every day (No change from current process)	Hospital UR applying Medi-Cal policy and requirements – DHCS to review a focused statistically valid sample
Acute Inpatient Intensive Rehabilitation (AIIR)	TAR every day (No change from current process)	Hospital UR utilizing InterQual®/MCG – DHCS to review a statistically valid sample (Recent change)
Hospice – General Inpatient Care	TAR every day (No change from current process)	TAR every day

* Hospital UR for the admission utilizing InterQual®/MCG replaces TAR; no TAR required.

II. TREATMENT AUTHORIZATION REQUEST PROCESS

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.

On July 1, 2013 and January 1, 2014, respectively, all private hospitals and Non-Designated Public Hospitals (NDPHs) transitioned from billing each day of an approved acute inpatient stay to a payment methodology based on DRGs as mandated by Welfare & Institutions Code section 14105.28. As a result of this change in payment methodology, DHCS transitioned NDPHs and private hospitals from submitting a TAR to the field office for each day of a hospital stay for full scope FFS beneficiaries, to submitting a TAR for determination of the medical necessity of the admission.

A. Services Requiring a TAR

The following list describes in more detail the services and beneficiaries from **Table 1** where a TAR will continue to be required. These admissions constitute approximately 13 percent of all general acute admissions at NDPH and private hospitals:

1. Restricted Aid Code Beneficiaries

Applicable to NDPHs and Private Hospitals only
Beneficiaries in this category are only eligible to receive acute inpatient hospital services that are covered under their aid code, and this restricted aid code policy cannot be programmed into the standardized medical review criteria and was identified as an issue during the Designated Public Hospital (DPH) conversion to 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.

2. Obstetrics (OB) Admissions

Applicable to NDPHs and Private Hospitals only
A TAR is required for OB admissions *without* a delivery for restricted aid code beneficiaries only. For full scope beneficiaries *without* a delivery, the hospital will utilize standardized medical review criteria for the admission.

For OB admissions *with* a delivery, the hospital may directly claim; no TAR or standardized medical criteria admission review is required.

3. Acute Administrative Days

Applicable to NDPHs and Private Hospitals only
Acute administrative days in NDPHs and private hospitals are not being paid using the DRG methodology because the logic for this lower level of criteria is not

included in the DRG algorithm. Therefore, utilization management of acute Administrative Days must be adjudicated outside of that process and require a daily TAR for these inpatient service types.

4. Hospice – Acute General Inpatient

Applicable to All Hospitals
A TAR is required every day for acute general inpatient hospice. This applies to all hospitals.

5. Acute Inpatient Intensive Rehabilitation (AIIR)

Applicable to NDPHs and Private Hospitals only
A TAR is required every day for AIIR at NDPHs and private hospitals only.

6. Acute Inpatient Services at Out-of-State Hospitals

A TAR is required for all acute inpatient services rendered at hospitals physically located outside of California with the exception of OB admissions with a delivery and well-baby stays.

B. 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, 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.

C. 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.

D. Alameda Health System

Alameda Health System (AHS) is specifically excluded from the TAR process, 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, AHS fully implemented InterQual® for the determination of medical necessity for acute inpatient hospital stays and participates in the DPH process.

III. MONITORING AND OVERSIGHT OF HOSPITALS' USE OF EVIDENCE-BASED STANDARDIZED MEDICAL REVIEW CRITERIA

A. Designated Public Hospitals

Beginning in 2008, the acute inpatient utilization review activities for DPHs transitioned from DHCS performing the daily review of 100 percent of all hospital days to having the DPHs perform their own acute inpatient utilization review using evidence-based standardized medical review criteria, such as InterQual® or MCG. These criteria are industry standards based on a solid, scientifically valid foundation of medical evidence which improves quality and increases efficiency.

As of January 1, 2015, all 21 DPHs have completed the aforementioned transition.

DHCS Medical Consultants use DPH admission data to perform independent oversight and monitoring to ensure federal funds are claimed appropriately. This is done by reviewing a statistically valid sample of cases to determine if a hospital is appropriately using standardized medical review criteria. In addition, DHCS may augment the sample with focused reviews to ensure that Medi-Cal policy is 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 services covered by a beneficiary's aid code and any emergency services are medically necessary under the State and Federal definition.

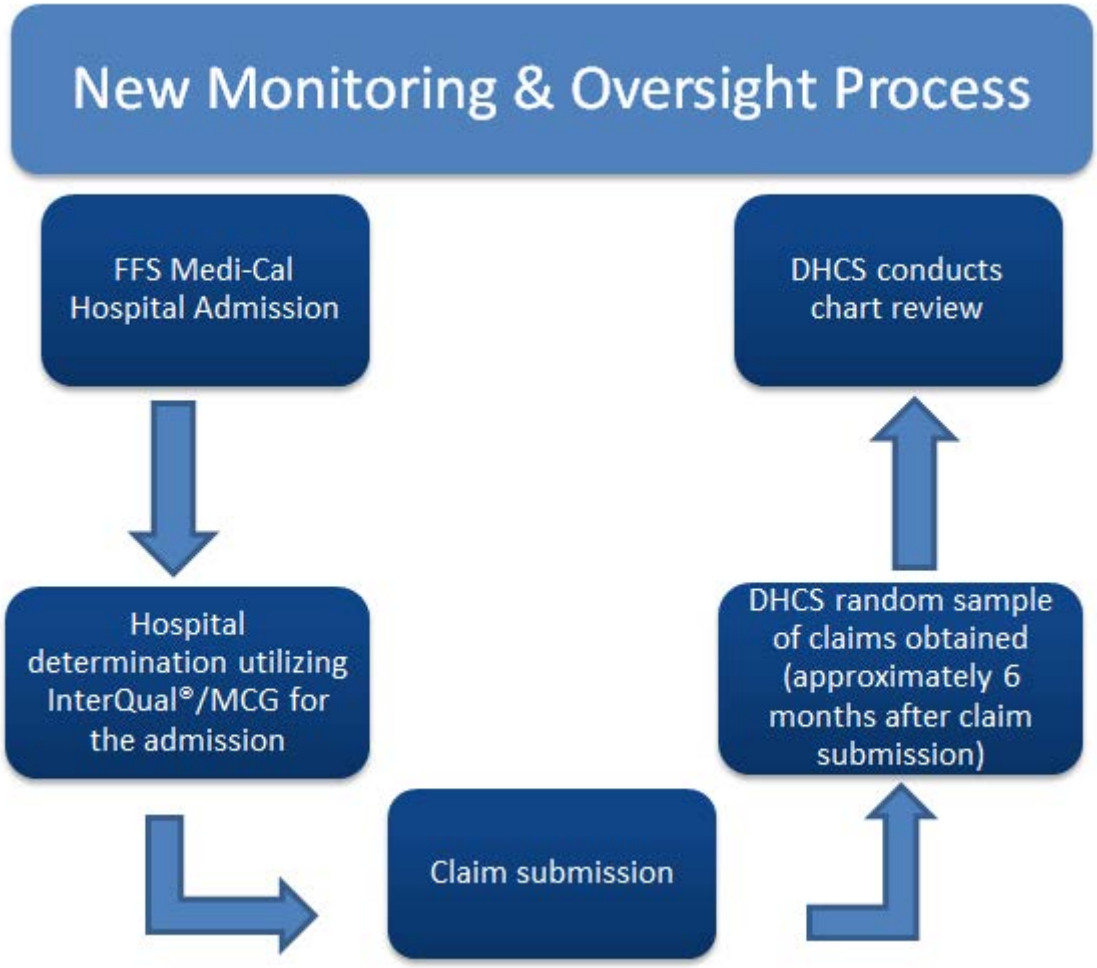
B. Non-Designated Public Hospitals & Private Hospitals

With this waiver renewal, subject to completion of California's Medicaid payment system modifications, effective January 1, 2016 DHCS will begin collaborating with all NDPHs and private hospitals to transition away from the hospital admission TAR process to performing their own utilization review using evidence-based standardized medical review criteria for certain admissions. This process will be much like the DPH process and is projected to take approximately two years with a phased approach based in part on a hospital's Electronic Medical Record capabilities.

Once implemented, DHCS plans to host quarterly conference call to provide a forum for all hospitals to share information and to receive updates from DHCS.

Diagram 1 provides an overview of the DHCS monitoring and oversight process for NDPHs and private hospitals.

DIAGRAM 1



Unlike the DPHs, due to the aforementioned DRG payment methodology, both NDPHs and private hospitals will need to continue to submit a daily TAR for:

- Restricted aid code beneficiaries for all acute inpatient days; as DHCS must continue to review each day of services for these beneficiaries to ensure that the hospital is compliant with state and federal policy
- Administrative Days – Level 1 and 2
- Acute Inpatient Intensive Rehabilitation (AIIR)
- Hospice General Inpatient Care

Per Welfare and Institutions Code, section 14105.28 subdivision (b)(1)(A)(i), DPHs , psychiatric hospitals, and AIIR 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) AIIR days; 3) managed care inpatient days; and 4) swing bed stays for long-term care services. Psychiatric and AIIR 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.

DHCS will use paid claims data to create a random post-payment sample. The records associated with the random sample will be reviewed by DHCS Nurses and Medical Consultants to validate the appropriate use of standardized medical review criteria and Medi-Cal policy. Any cases authorized through a hospital's secondary review process that are part of the random sample will be reviewed by DHCS Medical Consultants who are California licensed physicians.

DHCS has developed a schedule (on page 16), to reflect when key activities in the NDPH/private hospital transition to standardized medical review criteria will occur. This process is similar to the process used for the DPH transition, while taking into consideration and incorporating those characteristics unique to these hospitals, such as the low volume of FFS Medi-Cal beneficiaries at some NDPHs and potential inexperience of some hospitals with Medi-Cal policies.

C. Program Requirements Applicable to All Hospital Types

Standardized Medical Review Criteria Software – Use Current Version

Due to changes in medical practice, evidence based standardized medical review criteria software is evolving and there are updates annually. To ensure consistency and standardization, DHCS requires that hospitals use the most current electronic version available.

Hospital Training

DHCS provides training of applicable hospital UR staff on the TAR-free process, requirements, and relevant Medi-Cal policies prior to beginning the new utilization review process. Training is for specific Medi-Cal criteria that are not captured using standardized review criteria (e.g., acute administrative days and restricted aid codes).

In addition, DHCS provides training, technical assistance and clarification regarding clinical review findings. Additional assistance for hospital UR staff is available if needed for: using the Medi-Cal Provider Manual, navigating the Medi-Cal and DHCS websites, and policy updates/clarification.

III. MONITORING AND OVERSIGHT OF HOSPITALS' USE OF EVIDENCE-BASED STANDARDIZED MEDICAL REVIEW CRITERIA, continued

Participation Agreement

Prior to using standardized medical review criteria, hospitals must sign a Participation Agreement which delineates the basic requirements the hospital must meet. The participation agreement includes information on: TAR-free claiming, reporting requirements; the UR process, including having a UR Committee, the secondary review process and requirements, and DHCS oversight responsibilities.

Dispute Resolution

Similar to a TAR appeal, a dispute resolution process exists for clinical findings. In this process, if a hospital disagrees with a DHCS clinical finding, it may submit a Dispute Resolution form electronically with attached documentation to support the reason(s) for the dispute. A DHCS Medical Consultant will review the documentation received and make an independent determination to either uphold or reverse the determination in part or in full.

Referral to Audits & Investigations

There is a potential for referral to DHCS Audits & Investigations (A&I) if:

- Continued issues with the UR process are identified;
- Claims for hospital stays are not voided as requested by DHCS; and/or
- Hospital staff training issues identified by DHCS are not corrected.

This referral to A&I would only occur after the DHCS Clinical Assurance and Administrative Support Division (CAASD) has worked with a hospital to correct issues. This could include additional training and technical assistance. If a hospital is deemed non-compliant with the requirements that govern the utilization management process, DHCS may require another method of utilization review.

IV. 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 CAASD established the Clinical Program Integrity Branch. Staff in this Branch is primarily responsible for the following:

(a) Oversight and monitoring of the DPHs and DRG payment methodology hospitals for consistency of application of the Medi-Cal specific policies and appropriateness of services;

(b) Ensuring the standardization and consistency of the field office TAR adjudication and DPH process;

(c) Monitoring the DHCS utilization management 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. Standardization and Consistency

Standardization and consistency 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 DPHs, NDPHs and private hospitals. This approach assists providers to understand the criteria that are used in evaluating their TARs and UR processes. To the extent this is achieved, the number of TAR denials and DPH process variances decrease over time.

The Clinical Program Integrity Branch is staffed with physicians, 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 standardization and consistency that is critical to California's utilization review system.

The Medi-Cal Manual of Criteria is used to maintain consistent TAR adjudication guidelines for DHCS Medical Consultants in rendering professional opinions. DHCS Headquarters conducts monthly staff meetings and training sessions with Medi-Cal Field Offices to reinforce existing guidelines and learn about new issues. The Medical Consultants provide guidance to the Nurse Evaluators as they identify issues with TARs and the DPH process. 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.

All CAASD Nurse Evaluators and Medical Consultants have online access to State and Federal regulations and utilize their clinical expertise and professional judgment to render TAR adjudications and DPH process 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 and DPH process 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 management system is accomplished in the following ways:

a. Analysis of TAR and TAR-free admission data generated by the Clinical Program Integrity Branch; and

b. TAR adjudication and DPH process decision monitoring by Medical Consultants (both physicians and nurses) located at CAASD Headquarters.

1. 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 at DHCS Headquarters. Medical Consultants use reports to assist in monitoring utilization trends to identify areas amenable to early intervention and problem resolution.

2. Variance Data

One of the key components of monitoring utilization management is the review and analysis of variance 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. CAASD's TAR statistics, as shown in the table below, for the period of Calendar Years 2005 through 2014 indicate an upward trend in approval rates. DHCS believes this is, in part, a function of providers' clearer understanding of the requirements of medical necessity, and because of the implementation of the DRG payment methodology for NDPH and private hospitals.

Acute Inpatient Hospital TAR Approval Rate	
2005	70%
2006	77%
2007	79%
2008	83%
2009	78%
2010	82%
2011	83%
2012	82%
2013	81%
2014	86%

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, dispute resolution, and litigation decisions monitored to identify areas in need of policy clarification.

V. JUSTIFICATION

Justification of the Waiver Program as a Superior System

California's Medi-Cal SSW program constitutes a superior system for the following reasons:

- DHCS will continue to use utilization review methods other than TARs. However, because the acute inpatient hospital stay is one of the more costly Medi-Cal services, there is significant value in continuing to conduct a 100 percent review of specific TAR types. These TARs will continue to be adjudicated based on a determination of medical necessity. This use of TARs in conjunction with oversight of hospitals' use of InterQual and/or MCG is superior to federal requirements which allow 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.

- It is more appropriate for DHCS Medical Consultants (nurses and physicians) who are independent from a specific hospital review committee to make decisions regarding medically necessary hospital stays. State Medical Consultants perform independent oversight to ensure federal funds are claimed appropriately. Licensed State physicians review the most complex TARs, while State Nurse Evaluators review all other TAR types. TARs not recommended for full approval by a Nurse Evaluator are further reviewed by a licensed State physician (field office Medical Consultant) before the adjudication decision is issued.

- Because DHCS 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.

- 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 Medi-Cal Manual of Criteria 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).

- By incorporating formal appeal and dispute resolution processes handled by State staff, the SSW provides a second independent review to ensure accurate TAR adjudications and review decisions. The overall accuracy of those adjudications is demonstrated by the fact that in 2014, less than five 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 and dispute resolution processes offer a relatively inexpensive administrative remedy in order to avoid the need for costly litigation.

- The SSW utilizes the utilization management approach that best meet the needs of different hospital types (NDPHs/private hospitals vs. DPHs).

Application of Technology

As technology continues to advance, there is the potential to further automate the TAR and TAR-Free processes. For example, DHCS continues to transition to virtual on-site hospital record reviews, in which DHCS Medical Consultants review electronic medical records (EMRs) remotely from the field offices. This process reduces the need for Medical Consultants to travel hospitals to review records on-site. This is a more efficient process than having hospitals pull hard copy records for on-site reviews or copying and mailing records to the field offices. Whenever possible, DHCS will conduct reviews virtually, allowing hospitals to produce medical records and case management notes electronically. Whenever feasible, hospitals will not be required to produce proof of Medi-Cal eligibility as part of the review process.

Moreover, more providers are now submitting TARs to DHCS electronically. Currently, approximately, 85 percent of medical providers submit electronic TARs. This mode of submission is far more efficient than mailing or faxing and allows providers to receive TAR adjudication responses more rapidly.

Provider use of EMRs and electronic TARs gives DHCS the ability to better manage workload. Through these electronic processes, DHCS can shift workload between field offices based on available resources, expertise, or other factors in order to maximize efficiency.

TENTATIVE SCHEDULE FOR TRANSITIONING NON-DESIGNATED PUBLIC HOSPITALS AND PRIVATE HOSPITALS TO STANDARDIZED MEDICAL REVIEW CRITERIA

Activity	Timeframe
Update NDPH/Private Hospital List o Contact info o CFO and Hospital (Case Manager) Contact	**July – September 2014**
Create Communication / Stakeholder Engagement Plan o Engage hospital associations o Develop a Recurring Stakeholder Meeting/Teleconference ▪ Develop Stakeholder Meeting Schedule o Provider Outreach ▪ Web/provider bulletins and manual updates as appropriate	**July 2014 and ongoing**
Research/Gather Data o Obtain current monthly Medi-Cal Fee-For-Service (FFS) admission volume o Survey hospitals on their use of InterQual®/MCG	**September – October 2014 (NDPHs)** **July – August 2015 (Private Hospitals)**
Create Internal Work Group o CAASD/SNFD/CA-MMIS/A&I ▪ Determine division responsibility by task	**September – October 2014**
Develop Oversight / Monitoring Plan o Using the current DPH process as a base, tailor NDPH and Private Hospital oversight and monitoring. ▪ Determine variance threshold based on smaller volume ▪ Determine compliance review schedule (quarterly/semi-annually/annually) ▪ Determine compliance review modality (on-site, virtual, etc.) o Modify *Memorandum of Understanding* with A&I to include NDPHs and Private Hospitals	**January – June 2015**
Develop / Conduct Provider Training o Develop training curriculum and schedule o Create Webinars o Train NDPHs and Private Hospitals	**October 2015 and ongoing**
Convert NDPH/Private Hospital Utilization Management to Standardized Medical Review Criteria	**January 2016-January 2018**

VI. TRIBAL NOTIFICATION

In an email correspondence from CMS dated February 20, 2015, CMS indicated that tribal notification for the Superior System Waiver renewal was not necessary.

VII. 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. 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.

For OB admissions *with* a delivery, the hospital may directly claim; no TAR or standardized medical criteria admission review is required.

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.

C. Psychiatric Services

Distinct psychiatric inpatient days that occur in the State of California shall be excluded regardless of whether the stay is in a distinct-part unit of a general acute care hospital or other hospital categorization, as these services are approved by the counties, and are outside of this waiver. Psychiatric hospitals are specifically excluded from this waiver.

VIII. ATTACHMENT 1: MEDI-CAL SUPERIOR SYSTEMS WAIVER SUMMARY

Type of Waiver:	1903(i)(4)
Proposed Renewal Term:	October 1, 2015 through September 30, 2017
Program Services Area:	Statewide
Department of Health Care Services (DHCS) Contact:	Doug Robins, Chief, Clinical Assurance and Administrative Support Division (CAASD)

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, and to use the utilization management approach that best meets the needs of the distinct hospital types in California.

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.

DHCS utilizes two approaches to acute inpatient utilization management, depending on the type of acute inpatient service, the hospital type, and the characteristics of the beneficiary's health care coverage. These approaches are:

- **Treatment Authorization Request (TAR) process,** where hospitals submit TAR requests to DHCS for review and approval prior to claiming for services; and

- **Monitoring and oversight process,** where hospitals use evidence-based standardized medical review criteria to determine medical necessity, claim for services, and then DHCS performs a compliance review**.**

California Medi-Cal Superior Systems Waiver:

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

1. **Sampling Method for Utilization Review**

   The SSW requires 100 percent review of certain hospitalizations for specific types of acute inpatient services. For Designated Public Hospitals (DPHs), non-Designated Public Hospitals, and private hospitals the SSW requires 100 percent utilization review using a standardized medical review criteria such as InterQual® or MCG. 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 that TARs be adjudicated by and monitoring and oversight 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 their own TARs.

3. **Authorization of Services includes Professional Judgment**

   The SSW requires all State-employed Nurse Evaluators and Medical Consultants to utilize the Manual of 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 Processes**

   The formal appeal processes that accompanies the State adjudication of the service requests 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:

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. TAR-Free Obstetrical Acute Care

   For OB admissions *with* a delivery, the hospital may directly claim; no TAR or standardized medical criteria admission review is required.

3. Psychiatric Services

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