

**Questions and Responses from the
Department of Health Care Services (DHCS) Medi-Cal Tribal
And Indian Health Program Designee Annual Meeting on March 1, 2016
As of 8/2/16**

Please note this document will be updated as further information becomes available.

Meeting Purpose & Background & Indian Health Update

1. **Question:** With the opening of a California Youth Regional Treatment Center (YRTC) in California, will tribal health programs continue to send American Indian (AI) youth to YRTCs located outside of California?

DHCS Response: DHCS will have to look at utilization to determine if the needs of California's American Indian youth are being met. Certainly if there is a need to continue sending youth to the out-of-state YRTCs, the Department will continue to allow for that to take place.

2. **Question:** Regarding the tribal notice for State Plan Amendment (SPA) 15-037 sent in December of 2015 regarding Indian Health Service/Memorandum of Agreement (IHS/MOA) providers to be recognized as Federally Qualified Health Centers (FQHCs), what does the proposal do? My concern is there was no clarity to the definition of the IHS/MOA. You presented information at the last consultation on the difference between the two and I thought the issue was put to rest; however, with the recent notice, it seems this is not the case.

DHCS Response: DHCS had proposed SPA 15-037 following conversations with the Centers for Medicare and Medicaid Services (CMS) and Federal Health and Human Services Agency who had heard from tribes during their consultation that the FQHC definition was an issue for California IHS/MOA providers. DHCS also heard related concerns from tribal clinics regarding issues with managed care plans with specific activities focused on FQHCs in which IHS/MOAs could not participate. The SPA's intent was to align the definition of the California IHS/MOA provider with the Social Security Act's federal definition of a tribal health program which is included in the FQHC provider definition. This SPA would have allowed the IHS/MOA providers to be included in budget proposals, legislation, pilot projects currently impacting FQHCs only. It would have also allowed billing for services previously available only to FQHCs due to the Optional Benefits Exclusion policy implemented in 2009. DHCS was moving forward to address any disparity by submission of SPA 15-037. The SPA was approved by CMS for an expedited Tribal and designees of Indian health programs notification process. This SPA proposal has been withdrawn by DHCS due to concerns of CMS and the tribal health programs

3. **Question:** In regards to the CMS Letter regarding 100% FMAP, CRIHB is requesting data from DHCS to conduct research on impact on budget content just addressed and discussion later today with CMS.
 1. What was paid out to non-MOA providers in 2015 and the number of encounters for AIs?

2. What are the numbers of American Indians and non-American Indians seen outside of MOAs?
3. What types of services provided for AIs at state and county levels outside of provider type 075?
4. What was the number of AI in Medi-Cal for prior to ACA and now?
5. What was the number of primary care providers prior to ACA?
6. What was the number of specialty care providers prior to ACA?
7. What is the number of primary care providers after ACA?
8. What is the number of specialty care providers after ACA?

This Information will help identify what services AIs are receiving outside of the tribal clinics, allow tribal health programs to look at providing other types of services or contracting to provide these services at their clinic. CRIHB is requesting this data to determine how best to meet the needs of tribal members and expand services; address shortages reported by many tribal programs; however, CRIHB must have the data for this. We want to partner with the state to increase access and services through the tribal health programs. Look into discussing further strengthen tribal health programs, encourage providers to work with tribal clinics, to look for ways to move forward to find medical referrals for the tribal program patients.

DHCS Response: DHCS data is available by either accessing the California Health and Human Services Agency (CHHS) Open Data portal, which makes available statistics and reports produced by Department programs as well as links to other data related to DHCS programs. The open data portal can be found at chhs.data.ca.gov. For data that is not readily available interested parties can request data by following the process outlined on the DHCS website at: <http://www.dhcs.ca.gov/dataandstats/data/Pages/AccessingProtectedData.aspx>.

Drug Medi-Cal Organized Delivery System Waiver Update

4. **Question:** Throughout this presentation the program is referred to as a tribal implementation then Friendship House is included and visited, how are urbans eligible to participate? Do you have to be a 638 IHS/MOA provider, please provide more information on who is eligible.

DHCS Response: The program is referred to as the Tribal Organized Delivery System. All providers are eligible to participate.

5. **Comment:** We do not care what it is called; we are only interested in who is eligible.

DHCS Response: All providers are eligible to participate. Please see STC 144 C Selection Criteria and Provider Contracting Requirements, STC 149 Coordination with DMC-ODS Providers, and STC 154 regarding ASAM Designation for Residential Providers.

6. **Question:** Friendship House is participating with San Francisco in phase I. We are in the process of submitting an application and obtaining American Society of Addiction Medicine (ASAM) designation. Having problem with the County ASAM training, it is not adequate, and has limited seating. Staff required to take training are away from seeing clients. Will there be more training offered? Will the providers be reimbursed for training? There is already a tool intact with ASAM. How will ASAM be used, will it be similar to current process? Can the tribal electronic system be used? Deal with more auditing through this program, this is a burden.

There are only six or seven providers in San Francisco with only 360 beds currently in San Francisco going through the county process. Having to contract with each county or different tribes is cumbersome. It would be easier to work with the state. Would rather go through a government to government process. Funds going to county should go to the tribes and be used for care.

DHCS Response: Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the ASAM Criteria for substance use disorder treatment services, thus these trainings are beneficial for staff to complete. DHCS is also working with UCLA on creating a fast, free web-based placement tool that is based on the ASAM Criteria, but adapted to the needs of California counties and providers participating in the DMC-ODS Demonstration. Furthermore, California Institute for Behavioral Health Solutions will also be providing technical assistance around ASAM.

7. **Question:** This model seems interesting, but we are concerned that in COHS and tribally organized health systems we would be financially responsible for implementation, but there is no money set aside to take on this responsibility. How do we implement these changes? It will be extremely difficult to take this on statewide. Maybe this is something CRIHB can take on? On the other side, sometimes counties are good partners sometimes they are not. I have worked with both. Trying to work with them may be a better way in the long run if someone is willing to step up and take on that responsibility we may be interested in partnering with them. See positives and concerns on the financial and legal requirements.

DHCS Response: This is an ideal time to collaborate with programs, leaders, and partners to elevate and improve health care for tribal beneficiaries.

8. **Question:** When will we meet the consultants so we can start to have that dialogue? Were there other visits besides Friendship House?

DHCS Response: CMS consultants are already meeting with tribal partners to provide initial technical assistance. DHCS will offer more in-depth technical assistance with tribal partners in Phase 5 of waiver implementation.

9. **Question:** Why is reimbursement at 75%, not 100% FMAP?

DHCS Response: As soon as we hear from CMS regarding FMAP DHCS will provide the information.

10. **Comment:** CMS consultants are currently interacting agency to agency through Indian Health Services .CCUIH has been able to participate informally on those calls. Consultants have reached out to other urban residential treatment centers, Three Rivers Lodge in Manteca to starting talking out a lot of these outstanding questions. Need to get this in front of tribal leaders for approval. This will be presented next week at IHS meeting. Once approval is received many stakeholders and designees put forward can begin discussing and operationalizing some of these difficult issues. Some of us are currently looking at strategizing some of the financial issues discussed already to bring forward once approval is received.

DHCS Response: CCUIH thank you for sharing your approaches with the group. These are the steps and actions that are needed to provide Indian beneficiaries with access to care and system interaction in order to achieve sustainable recovery.

11. Question: What happened to the SUDS advisory group? What has taken its' place?

DHCS Response: DHCS convened the Waiver Advisory Group in order to create the DMC-ODS system. Currently, DHCS is providing technical assistance based on the phased roll-out. The tribal phase is in Phase 5.

12. Question: Are there startup funds for the counties? How are the other phases being paid for?

DHCS Response: There are no funds for startup costs.

13. Question: Without startup funds, how are the counties able to implement? Counties receive reoccurring funding from the state Proposition 63, the Mental Health Services Act; these funds go directly to the 58 counties. There are challenges for THPs in contracting with counties for the delivery of mental health services. Counties are better situated to implement this program than I/T/Us because Tribes do not have a recurring funding stream. It would be beneficial for the I/T/Us to be treated the same as the counties, perhaps adding them as the 59th county in California. Encourage additional outreach to existing programs.

DHCS Response: Correct, the funds from the state Proposition 63 are specified in law to be used for Mental Health Services; aside from co-occurring. Counties are looking to other resources to participate in this demonstration. DHCS is currently hosting county webinars and fiscal TA calls to assist with fiscal inquires and challenges. DHCS will offer the same technical assistance to Phase 5.

14. Comment: Regarding dual diagnosed AIs, medical condition such as head trauma, and drug use often go hand in hand. How will that be paid for? They go hand in hand. We are working with counties for the homeless non AI population and the AI population. There needs to be an accounting or survey, we are receiving no help from the county for the non-AI homeless. The Veteran's Administration (VA) stepped up and is helping their veterans; DHCS should look to the VA on how they have accomplished this.

DHCS Response: The tribal portions of the DMC-ODS have not been developed. Now is the opportunity for the tribal partners to share ideas, develop strategies, and propose ideas for DHCS to consider regarding Phase 5 implementation.

15. Question: Have you received feedback from counties for Phase 5? Are they concerned that funding will be extracted from the counties if Native American funds are pulled out? This is an opportunity for us to pursue however, I understand the counties may be concerned about losing funds.

DHCS Response: Counties recognize the tribal delivery system will be outlined in Phase 5.

Audits & Investigations Update

16. Comment: Billing process for THPs there are so many issues, tribes are able to bill the federal rate regardless, and to get the rate is burdensome, there is a significant barrier, enormous problems and costs for the THP, the state, and the Audits and Investigations Division (A&I) to reconcile the claims. Clinics have to submit duplicate bills, this is only happening in California. Other states have a pass through for tribal members in a managed care plans, the claims are paid at the full amount. Payment is received in two weeks, no later than 30 days; it takes up to three years for California THPs to receive full funding. One of the most important issues for the tribal programs is getting the third party revenue back. We depend on those funds. DHCS needs to look into changing this reimbursement policy. Look to a system that fosters a better partnership.

DHCS Response: The Department is reviewing these concerns.

17. Comment: We have a contract with the state of CA to receive our federal rate. We bill managed care; however, we are not contracted with the managed care plan and do not deal with capitation. We bill the plan, bill Medi-Cal, and Medicare if applicable. Have to get reconciliation in by end of May each year, and state waits a year to review, and continues to acquire data as many claims are not completed in time for the reconciliation, claims continue to be processed by third party payers. So, by the time we receive information from A&I, our numbers are completely different because they waited a year to look at the data that I was required to look at a year previously. A&I will then decide to pay 60% and take up to three years to finish the audit.

DHCS Response: A&I will work with each provider in resolving issues the clinic may encounter with the reconciliation process. Please email the clinics inbox at clinics@dhcs.ca.gov or if your clinic's reconciliation is being processed, you may inform the auditor of your clinic's situation.

18. Question: We are having the issues with managed care claims, and Code 18 rate and the reconciliation process, we are not made whole, and in some cases receiving too much payment when billing managed care, Medicare, and Medi-Cal, why have the same billing code for all? There is no clear pathway to ensure we do not get overpaid. Seems to be an easier way to do this.

DHCS Response: We understand that the billing process may not be easy. However, since the payor funding sources are different (i.e., Medicare, Managed Care Plans, Medi-Cal, private pay, etc.), the reconciliation process is necessary to ensure the clinics are made whole up to the MOA rate. The clinics should perform an internal analysis and assess what the interim rates should be set at. If the interim rates need to be changed, the clinic may do this at any time by notifying A&I via the clinics mailbox at clinics@dhcs.ca.gov

19. Question: When did the requirement for reconciliation of code 18 change?

DHCS Response: The reconciliation process has been in effect for FQHC/RHC providers. For MOA providers, the reconciliation process for code 18 was required after the managed care expansion in 2013.

20. Question: Did you notify MOA providers that new forms are available? Also, I see the requirement to file reconciliation electronically in your presentation, did you send out notification regarding this?

DHCS Response: We are in the process of mailing notifications regarding the new electronic submission process to providers. This information will also be available at:
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

21. Question: What can be done, all three payments received from Medicare, Medi-Cal and Plan results in an overpayment. The mix is constantly changing, if adjusted too low, we will end up with an underpayment. What does DHCS suggest to avoid this?

DHCS Response: See response to question 3 above.

22. Question: Maybe DHCS should add a section to the reconciliation form to incorporate the analysis in the worksheet?

DHCS Response: You may contact our office for more information. We suggest you observe your clinic's Medi-Cal reimbursement for a period of three months and if it appears to be excessive or insufficient, you may consider adjusting it at that time. You may reassess every few months to check if the clinic's rates need to be adjusted. You may contact us by emailing the clinics mailbox at clinics@dhcs.ca.gov to have your rate adjusted accordingly.

23. Comment: This will be a huge issue with the recent change from CMS for 100% FMAP. If this issue is not resolved it will be disastrous for the tribes and the state. There are other region 9 states that have the pass through in place. I encourage you to push this.

DHCS Response: The Department is reviewing this concern.

24. Question: When is the electronic submission in effect? If we already submitted on paper, will it be returned now that electronic submission is required?

DHCS Response: You may submit hard copies of the forms until the notification of the electronic submission are mailed and posted on the DHCS forms webpage. If you have already submitted on paper, they will not be returned.

25. Question: In regards to reconciliation using Xerox payment data, Xerox is not always right, they make mistakes on claims, the Department should not always rely on what Xerox payment data shows. We have had this issue for over 13 years; we are not getting paid for the services provided. We do everything we are asked to do. Trying to estimate payments from three payers is extremely difficult. We get claims corrected and if they are too late to include in reconciliation, we lose out. We are left with no ability to argue, or receive payment correction. Submit CHDP claims instantly should get full-scope Medi-Cal; however, before warrant is

issued, claim is kicked out, patient enrolled in managed care, we then bill managed care, claim is denied as duplicate. Try to explain to Xerox, and never receive payment for this. There is not enough time to review A&I reconciliation review and make a decision to accept their findings, two weeks is not enough time. About 2% error rate by Xerox, it adds up to quite a lot of money if you look at the DHCS total budget, these are claims never looked at.

DHCS Response: In regards to the 2 weeks not being enough time: If the 15 day review period is not sufficient, the provider may request additional time to review the audit findings during this period. The phone number for the auditor that reviewed the reconciliation is noted on the 15 day letter. You must contact the auditor and request an extension of time if it is needed.

26. Question: The [reconciliation] process needs to be improved, with the 100% FMAP will be a disaster if we implement, it is supposed to be a benefit. Consolidated Tribal Health Program has been waiting two plus years for A&I to complete their reconciliation and have been offered 60%, we have to wait for the other 40%. This is a hardship. Additionally, can we update our annual rate via email when the new rate comes out?

DHCS Response: Even though the program is 100% federally funded for American Indian beneficiaries, the federal and state governments share responsibility to ensure proper and appropriate use of these funds. Therefore, the DHCS' reconciliation audits are necessary to ensure the regulatory requirements of the program are met.

Due to the workload and to ensure the statutory requirements are met, A&I makes every attempt to process the Reconciliation Requests in a timely manner. To provide cash flow for the providers, a 60% tentative settlement is issued in the interim.

You may request to have your interim rates adjusted at any time. For code 2 rate adjustment, you may email the clinics inbox at clinics@dhcs.ca.gov. For code 18 rate adjustment, DHCS Form 3100 will need to be completed and mailed to our office or scanned and sent to clinics@dhcs.ca.gov.

27. Question: Can we include late payment in the following year reconciliation? Still fighting for denials, and still waiting for 2013 and 2014 payments and reconciliation payments.

DHCS Response: The basis for reporting on the reconciliations is the 'Date of Service.' These 'interim' payments along with all other payments the provider received that are associated with any adjudicated visits occurring within the review period must be included in total payments, including payments for "incident to" services. If you are in a situation where additional time is needed to submit your reconciliation, you may request an extension to file your reconciliation forms.

28. Question: The process tribes have to go through to get their payment [is difficult]. Tribal health programs should not have this process. How much is pending in claims to tribes in the queue? It is a very large amount of money. Recommend Xerox have a tribal liaison dedicated to answer our questions and assist tribes with issues. Why does Xerox charge for payment data? It is our own data? Tribes should be exempt from this cost.

DHCS Response: California's State Plan requires the Department of Health Care Services make supplemental payments to FQHC/RHC/IHS/MOA providers for beneficiaries enrolled in Medi-Cal Managed Care Plans and Medicare. The reconciliation process is mandatory as this is an oversight process for the state government to ensure state and federal funds are being dispersed properly and appropriately.

The amount pending in claims to tribes cannot be calculated as the audit process for the reconciliations has not been completed for all providers. There may be incorrect reporting or incomplete reporting which may reduce the reported amounts by providers.

Unfortunately, the charges associated with claims data requests are not under DHCS authority.

Managed Care

29. Comment: We are an FQHC provider located in Santa Barbara, experiencing issue with CenCal as it relates to Medicare and Medi-Cal CHDP beneficiaries in Santa Barbara. Huge disconnect. There is a need for CenCal to understand FQHC roles, and the roles/responsibilities of the managed care plan. Would like to take part in the FQHC alternative payment methodology pilot project. They are the only managed care plan we have and it is their way or the highway. Great people to work with but that is the reality. For CenCal to head down this path whatever you can do to have them work with the organization would be greatly appreciated. Would love to be involved. Big concern coming out of this.

DHCS Response: DHCS appreciates the comment; however, it is not clear from the comment what the issue is. Per the contract, Child Health and Disability Prevention is not covered by CenCal as it is carved-out to Medi-Cal Fee-For-Service (FFS). If additional information is available, please contact DHCS by emailing us at mcqmd@dhcs.ca.gov.

30. Comment: In regards to managed care, there are significant barriers for Tribal Health Programs (THPs) in California that directly impact the THPs. Credentialing is redundant, credentialing for FFS and for managed care is adding additional work, is a significant barrier of tribal clinics. Other states do not require separate credentialing through their managed care plans, they accept the Medicaid credential. Look at ways to bypass that.

DHCS Response: Currently DHCS allows credentialing to be done at the Medi-Cal managed care health plan (MCP) level. DHCS certainly can and does encourage MCPs to accept credentialing done through other avenues but current contract language would make it difficult to mandate.

31. Comment: Managed Care is affecting staffing levels, for American Indian, primary care provider sent a referral, it is not known by the plan that the primary care provider is a THP; referrals are denied as out of network providers. In other states we requested the state auto-list all Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as in-network providers, this resolved the issue. Tribal programs are recognized as in network providers, this change cut down the denials, please consider this.

DHCS Response: DHCS suggests the THPs work closely with their provider relations representative at the MCP to find solutions in provider mapping and referral patterns to show that these providers are American Indian providers. As stated in the CMS Final Rule under CMS's authority in section 1902(a)(4) of the American Reinvestment and Recovery Act, a new requirement has been added under 42 Code of Federal Regulation Section 438.14(b)(6) to clarify that Managed Care Organizations must permit an out-of-network Indian Health Care Provider (IHCP) to refer an Indian to a network provider. This new regulation, effective for contracts with a rating period starting on or after July 1, 2017, would alleviate this issue as the referral must be accepted.

32. Question: There are issues with California Children's Services (CCS) and Managed Care, specifically with Inland Empire Health Program (IEHP) located in San Bernardino County. Will the redesign include IEHP? There are a number of managed care issues coordinating through CCS.

DHCS Response: IEHP is not currently scheduled to be included in the CCS redesign/Whole Child Model. Please provide DHCS with specific examples of issues related to IEHP and coordination of CCS by contacting us at mcqmd@dhcs.ca.gov.

33. Question: California Health and Wellness (CH&W) sent this 85-page document requesting all dates of services, from 2011-2015 to identify any provider type with CCS, CIS, CDC as a resource, require all records. Inc. labs, Dr. Notes; etc. for each and every visit in 2014-2015. The CIS include all DOS from both 2015. Can IHS upload this into Resource and Patient Management System (RPMS)? Our Electronic Health Record (EHR) will not allow, but this would help significantly if we could upload to RPMS. Has to be done by paper. We understand the requirement for the information but it is very burdensome to do manually.

DHCS Response: This was an isolated incident where the plan sent the document to the IHS clinic in error. This was discussed with CH&W and the matter has been resolved.

34. Question: License exemption per legislation, will this cause an issue with managed care? Do not want to get into an issue with not receiving payment due to this. Effective January 1, 2016, has information been communicated with the state and managed care? We do not want to get into a situation of not receiving payment because of the license issue.

DHCS Response: DHCS is unable to comment as it is not clear what specific legislation is being referenced. In addition, DHCS would need specific examples showing the payment issues referenced to formulate an accurate response. In any instance DHCS and MCPs would be required to adhere to any applicable state and federal requirements in relation to licensure. Please provide DHCS with further information to complete this request.

35. Question: We are not paid timely because the late credentialing by the plans. I have a new provider with denied claims from August through September, now credentialed but still trying to

get payment. These late payments due to late credentialing affects cost reports. What can be done to correct this?

DHCS Response: DHCS recommends the provider work with their MCP provider relations representative in finding a resolution to the billing issues. DHCS will continue to meet with MCP Chief Executive Officers and Chief Medical Officers to discuss accelerating the provider credentialing process. DHCS will also remind MCPs of their responsibilities to pay for services through FFS during the credentialing period and when care in general is accessed. DHCS continues to request feedback from stakeholders on which MCPs and/or counties have individuals who are experiencing these issues. To provide this information please contact DHCS by emailing us at mcqmd@dhcs.ca.gov.

36. Question: You stated Network sufficiency was in place prior to plan approval, we have two plans in our area and our clinic is the only one that accepts one of the plans, if we have to refer, there is no one to refer them to that will accept the plan. Referrals are so far away; we tell the clients to call their plan to see what can be done. Is network sufficiency continually under review or only at the time the plan is put in place?

DHCS Response: DHCS conducts a variety of activities to monitor and evaluate the adequacy of all MCP networks, as well as access to the health care services on a quarterly and ongoing basis. The monitoring tools include an extensive joint network review performed by DHCS and the Department of Managed Health Care on a quarterly basis. The quarterly joint reviews require all participating non-County Organized Health System MCPs to submit detailed reports related to out-of-network referrals. In addition, DHCS requires MCPs to provide provider data, which is evaluated to ensure that MCP members have access to primary care providers and other physicians and specialists. The monitoring tools are also utilized to ensure that MCPs have sufficient providers and are in compliance with all Knox-Keene Act requirements and the MCP contract. Through these mechanisms, DHCS is able to evaluate and monitor MCP provider networks on an ongoing basis.

Lastly, in rural counties, MCPs provide Non-Medical Transportation (NMT): 1) to get to and from medical appointments for screenings and/or needed treatment services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, or 2) to get to plan-covered services when a beneficiary's medical condition does not allow him/her to use medical transportation such as an ambulance, litter van or wheelchair van to get to the appointment.

Additionally, these MCPs allow beneficiaries to use a car, taxi, bus or other public/private way of getting to medical appointments for plan-covered medical services from those who are not Medi-Cal providers. These MCPs allow the lowest cost NMT type for the beneficiary's medical needs that is available at the time of their appointment.

37. Comment: This is more of a broader issue but kind of ties into managed care and many other things. Nice to have the DHCS Director, CMS, and IHS here today. Tribes are advocating for a standardized system utilized across the United States; there should be a streamlined

process for reporting. Example we are reporting on Government Performance and Results Act (GPRA) which does not tie 100% to the information in the HEDIS system; however, many are the same, we are submitting other documentation for, would be nice if you could look at some of these reporting requirements and push for a standardized streamlined system across the United States for not only IHS reporting but managed care and other reporting requirements. Data issues are just as important as financial issues.

DHCS Response: DHCS will redirect this question to the Centers for Medicare and Medicaid Services for response.

38. Question: Limited scope to FFS managed care for pregnant women. Issue with no specialty OB/GYNs located near clinic in Winterhaven, the nearest is located in El Central, and takes at least one hour to get to the location. This is a hardship for pregnant moms, especially those that are working to spend the time away from their jobs to travel to El Central for appointments. In Winterhaven area office of AZ, we cannot contract with managed care plans; this is encouraging pregnant women not to go through Indian Health service our clinic provides prenatal services; however, the women must travel to El Central for specialty care or delivery. Yuma Regional Medical Center located ten minutes from our clinic location has a program for non-working pregnant women; services are not available for low-income working moms. Many times the hospital ER in Yuma does not receive payment from the plans. Can there be an option for these women to receive services in Arizona? We have always had an issue with this. Birth is the only time Medi-Cal will pay. Services outside of California require pre-authorization for specialty care. Plans are able to have that criteria, unlike FFS. Provider must follow plan protocol. Is there a way to work with the managed care plans to allow our patients to cross the border to Yuma for treatment?

DHCS Response: DHCS has encouraged MCPs to extend contracts with bordering state providers to ensure greater network adequacy and accessibility. However, DHCS does not have regulatory authority to require providers to contract with MCPs. Emergency services occurring in other states are covered and must be reimbursed by MCPs. In addition, it is also common for specialty providers in rural areas to practice in the more densely populated areas of the county. American Indians may request a non-medical exemption (link provided) to be excused from MCP enrollment to receive medical services through an IHS facility or a provider of their choice. Non-medical exemption form, http://www.healthcareoptions.dhcs.ca.gov/hcocsp/enrollment/content/en/forms/MU_CCI3382_ENG_1114.pdf

However, effective for contracts with a rating period starting on or after January 1, 2017, the CMS Final Rule Title 42 Code of Federal Regulations Section 438.14(b)(1) will require managed care organizations to demonstrate that there are enough IHCP providers in their provider networks to ensure timely access to services available through such providers for those Indians eligible to receive these services. If managed care organizations are unable to ensure timely access to these services due to the lack of IHCPs in their service areas, they can meet this adequacy requirement by allowing Indian enrollees to access out-of-state IHCPs.

Lastly, DHCS conducts a quarterly joint network review with DMHC. For Quarter 3 of 2015 and Quarter 4 of 2015, there were no reported OB/GYN related out-of-network referrals reported by either of the two MCPs in Imperial County.

39. Question: We have to obtain pre-authorization from the plan for our patients to go outside of the clinic to see a specialty provider. Do we have to follow the pre-authorization requirement as a Medi-Cal provider?

DHCS Response: Medi-Cal FFS providers adhere to Treatment Authorization Requirements as outlined in the Medi-Cal Provider Manual. Per the contract, DHCS requires MCPs ensure timely access to emergency and non-emergency specialist visits. MCPs are not obligated to reimburse Federally Qualified Health Centers for services provided out-of-plan to MCP members unless authorized by the MCP.