Drug Medi-Cal Organized Delivery System: Common Compliance Issues and Relevant Resources

Technical Assistance Webinar for Counties

September 6, 2018

Overview of Presentation

- State Updates
- Common Compliance Issues and Relevant Resources
- Questions and Discussion
- Adjourn

State Updates

Drug Medi-Cal Organized Delivery System (DMC-ODS): Common Compliance Issues and Relevant Resources

Cynthia Hudgins
Department of Health Care Services (DHCS)
Substance Use Disorder Compliance Division

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DMC-ODS County Reviews

- The annual review process will continue with counties receiving a DMC-ODS monitoring instrument along with a Substance Abuse Prevention & Treatment Block Grant monitoring instrument.
- DMC-ODS counties receive onsite monitoring reviews and an exit conference is provided with preliminary results.
- Reports are issued and deficiencies require a Corrective Action Plan submission within 30 days of the issued report.
- Some of the deficiencies during the Fiscal Year 2017-18 cycle were identified as new requirements (NR) due to the timing of DHCS policy guidance on new federal regulations. NRs also require corrective action.
- All county performance reports are posted on the DHCS webpage.

Common Issue #1: Provider Directory

- The provider directory is missing elements such as:
  - Whether the provider will accept new beneficiaries
  - The provider's cultural and linguistic capabilities, including languages (including whether the provider has completed cultural competence training)
  - Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment

Provider Directory Resources

- Federal guidance on required elements of a provider directory is available in IN 18-020.
- DHCS also outlines specific elements required for the provider directory in the DMC-ODS Intergovernmental Agreement Template, on page 11.

Common Issue #2: Beneficiary Handbook

- The beneficiary handbook submitted did not match the approved DHCS approved handbook template; OR
- The beneficiary handbook was missing required criteria, such as:
  - A section on Emergency Services
  - A “Why is it Important to Read this Handbook?” section
  - A “Plan is Responsible” section
  - Taglines explaining where to access language-specific information

Beneficiary Handbook Resources

- DHCS has a beneficiary handbook template that outlines all criteria required for the handbook—specific examples for these criteria can be found:
  - Emergency Services—page 7
  - Why is it Important to Read this Handbook?—page 7
  - Plan is Responsible—page 8
  - Taglines—page 2

Common Issue #3: Credentialing and Re-Credentialing Policy and Procedures

- The Plan does not have, or did not provide the Plan's credentialing and re-credentialing of network providers policy and procedure.

Credentialing and Re-Credentialing Policy and Procedures Resources

- Statewide requirements for credentialing and re-credentialing of network providers are explained in IN 18-019.

Common Issue #4: Notice Templates Do Not Match DHCS

- Plan did not provide the Plan's finalized copy, or finalized copy did not match, DHCS-approved notice template(s) such as:
  - Notice of Grievance Resolution
  - Denial Notice
  - NOABD Your Rights Attachment
  - Adverse Benefit Determination Upheld
  - NAR Your Rights Attachment
  - Adverse Benefit Determination Overturned
  - Beneficiary Non-Discrimination Notice
  - Language Assistance Taglines
  - Authorization Delay Notice
  - Grievance and Appeal Timely Resolution Notice

DHCS Notice Templates

- Templates for these notices can be found on the DHCS website here.
- Ensure that your plan's copy matches the template, with consistency among naming conventions for the templates, and making sure any listed phone numbers are correct.
- Several plans want to include "right to a second opinion" on the Notice of Adverse Benefit Determination form. This is not allowed, however, plans may instead issue a form appended to the NOABD that explains the right to a second opinion.

Common Issue #5: Policy and Procedure for Selection and Retention of Network Providers

- The Plan did not provide a signed policy regarding the Plan's selection and retention of network providers; or
- The Plan's policy and procedure does not address non-discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment

Policy and Procedure for Selection and Retention of Network Providers Resources

- Guidelines for policy and procedure regarding selection and retention of providers can be found in the Intergovernmental Agreement template on page 25.
- See Information Notice #17-060

Common Issue #6: Coordination of Care Procedures

- The Plan's coordination of care procedures do not address how the Plan ensures certain requirements are met.
- Common missing elements include:
  - Ensuring that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
  - Making a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.

Coordination of Care Procedure Resources

- Guidelines for coordination of care procedures can be found in the Intergovernmental Agreement template on page 21.
- Procedures should be included in the MOUs with MCPs and Mental Health

Common Issue #7: CalOMS Tx Data Submission

- The Plan does not monitor its providers to ensure providers are compliant with the CalOMS Tx data submission requirements; or
- The Plan does not adequately monitor their CalOMS Tx reports:
  - Open Admissions Report
  - Open Providers Report

  - Most counties have long standing deficiencies with Open Admissions. Counties should have a system in place where this is routinely monitored.

*DHCS is actively working on a CalOMS re-write.

CalOMS Tx Data Submission Resources

- Information on proper data submission for Cal OMS Tx is available in the CalOMS Tx Data Collection Guide, posted on the DHCS website here.
- Follow link to CalOMS ITWS information:
  - http://www.dhcs.ca.gov/Search/Pages/Search.aspx?q=ITWS

Deficiencies at Provider Level

- Most commonly cited deficiencies at the provider level that counties should be monitoring for

Common Deficiencies from Provider Reviews in DMC-ODS Counties

- Providers do not have Medical Director policies and procedures developed
- Verification of required 5 Continuing Medical Education credits (CMEs) for the medical director not found
- Beneficiary not placed in level of care according to ASAM or ASAM appears inaccurate
- Counselors determining the diagnosis

Questions and Discussion

*For optimal sound quality, please ensure that you are dialed-in using your phone and that you have inputted your **audio PIN.***

DMC-ODS Resources

For additional information, please see the DMC-ODS Resources section of the DHCS Website: http://www.dhcs.ca.gov/provgovpart/Pages/DMC_ODS_Resources.aspx

For questions, please contact dmcodswaiver@dhcs.ca.gov

Harbage Consulting

Molly Brassil, MSW, Director, Behavioral Health Policy
molly@harbageconsulting.com
Don Kingdon, PhD, Principal
don@harbageconsulting.com
Courtney Kashiwagi, MPH, Program Manager
courtney@harbageconsulting.com
Chelsea Kelleher, MPP, Senior Policy Consultant
chelsea@harbageconsulting.com

Q&A from 9/6/18 DMC-ODS TA Webinar – Common Compliance Issues & Resources

1. **To clarify the fourth enclosure of the NOABD Delivery System does not apply?**
   Correct.

2. **Will there be any future trainings with NOABDs and example scenarios when a NOABD will apply?**
   Yes, in October 2018.

3. **Could you provide some examples of what is meant by "Cultural Capabilities" in regard to the Provider Directory?**
   Is the provider's facility wheelchair accessible, can the provider offer services in a language other than English, can the provider offer services to hard of hearing, or any other disability that may be a barrier to treatment.

4. **If a client drops out of services (and we've attempted t/c / USPS and home visit contact, etc.) & the client was informed at intake that no contact after ## days will result in being discharged from services, is a NOABD Termination required to be mailed to the client's last known address?**
   Yes

5. **In regard to an assessment progress note where there is 45 minutes of f2f time, 13 minutes of non-f2f time involved in completing the assessment form (reflecting the clinical content of that f2f session) and then 7 minutes to write the progress note: Is the expectation that we document the start time and end time for each of those activities?**
   Yes

6. **According to the CA RN Scope of Practice, RNs are allowed to diagnose or practice other delegated tasks under a standard operating procedure agreed upon by the organization. Has this been considered?**
   No

7. **Can you share the tentative dates for upcoming DHCS site reviews?**
   Many factors are considered when scheduling site reviews including weather conditions, holidays, and natural disasters. Analysts do not begin the scheduling process with the County until they are reasonably sure that the scheduled dates can be met. Providers are generally notified a minimum of 10 days prior to the review.

8. **A "loss of contact" discharge question - so when a client stops coming to treatment, a termination NOABD is required?**
   Correct

9. **Can you speak to what you have seen regarding recovery services?**
   Recovery Services is still quite new. At this point in time, there seems to be confusion regarding how to document. DHCS encourages counties to set guidelines for providers that allows for clear verification that billed services were rendered and supports program integrity.

10. **Our EHR requires a dx at the time of a service. Can the counselors or RNs enter a deferred Dx?**
    It is recommended that the diagnosis not be entered into the EHR until after it has been documented by the LPHA. Documentation of a diagnosis by a registered or certified counselor or RN would be out of the scope of practice for those professionals. Billing for ODS services is not required for six months after service delivery, therefore the EHR may be updated following the diagnosis by the LPHA.

11. **Can you please confirm there is a delivery system NOABD?**
    Not on the slide, but is referred to in the IN. The delivery system NOABD referred to in IN # 18-010 E does not apply to SUD. It is specific to Specialty Mental Health Services only.

12. **Also to confirm RN's cannot diagnose even though they are classified as an LPHA. Same as pharmacist.**
    Correct. Scope of Practice is the key. Pharmacists are listed as well but they cannot diagnose as it is not in their Scope of Practice.

13. **Follow up to NOABD for delivery system. I'm assuming this SUDS refers to ODS or is it state plan? The IN specifically states the following: "Delivery system Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services."**
    NOABDs currently apply to DMC-ODS Counties. This is a managed care requirement.

14. **Are there a set of guidelines to assist with monitoring for and matching ASAM Assessments with the designated level of care that can be provided?**
    We recommend the American Society of Addiction Medicine (ASAM) publication as a reference and all monitoring staff should be trained in ASAM as well.

15. **Our residential provider is rated for both 3.1 and 3.5 at same site. Should we use both designations if provider is providing level 3.5 to everyone**
    The level a beneficiary is admitted to should be determined by ASAM so they can participate in the least restrictive level of care that is medical necessary. The treatment plan should be individualized to the beneficiary so if 3.1 is warranted then whatever restrictions or differences specific to 3.5 would not apply to this beneficiary.

16. **Will discrepancies in ASAM level of care documentation (and actual level of care) lead to disallowances?**
    Not necessarily. It would depend on several factors including the reason for the difference.

17. **Any guidance on documentation standards for Recovery Services?**
    The IA is silent on documentation standards for Recovery Services. In this case it is the County's responsibility to determine requirements. Counties should consider how any service billed for can be verified through documentation requirements.

18. **Any guidance on documentation standards for WM?**
    The IA is silent on documentation requirements for WM. The County in collaboration with a physician trained in addiction withdrawal should develop these requirements.

19. **We are having an issue with an NTP that used to contract directly with the state. Our biggest problems are related to Beneficiary Protections -- they think the old rule about a hearing at the NTP applies, not the rules in 18-010E. Will this be clarified for them by DHCS?**
    All DMC-ODS providers must follow the requirements as outlined in the IA. The county is responsible for ensuring their providers' compliance with managed care requirement that include the provisions outlined in 18-010E. DHCS will be issuing a MHSUDS Information Notice that will include this topic

20. **We are a DMC-ODS county. What do you think is the best way to document the start and stop times for documentation and travel if the documentation occurs on a different day than the service?**
    Documentation does not have to be completed the same day the service is rendered. The service/documentation time/and travel time must be clearly described including date and start and end times. Beyond these requirements we encourage counties to set guidelines for providers that support program integrity.

21. **For number 7 timeliness of CalOMS data. What provisions are being made for the newly created error documents due to change in the system when moving from ITWS to BHIS (not allowing non-alpha characters such as -) and the data movement of the**

previous Direct Provider CalOMS data into the County's data bringing with it many old CalOMS as it relates to timeliness?
Please refer to CalOMS: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

22. **You had mentioned that the Medical Directors need the 5 CME's, do the LPHA's also need these 5CME's?**
All LPHAs including physicians must have 5 CEUs in addiction medicine each year. The IA does not differentiate between CMEs for physicians and CEUs for non- physicians.