Drug Medi-Cal Organized Delivery System: Beneficiary Informing

Technical Assistance Webinar for Counties

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Overview of Presentation

- State Updates
- Beneficiary Informing
- Questions and Discussion
- Adjourn

State Updates

Drug Medi-Cal Organized Delivery System (DMC-ODS): Beneficiary Informing

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County ODS Responsibilities

- Selective Provider Contracting
- Access
- Authorization for Residential
- Beneficiary Access Number
- **Beneficiary Informing**
- **Grievance and Appeal System**
- Care Coordination
- Quality Assessment and Performance Improvement
- Utilization Management

Beneficiary Informing

- Plans must provide information to beneficiaries in a manner and format that may be easily understood and is readily accessible.
- Beneficiary informing materials must be available at all DMC-ODS provider sites and must be provided to beneficiaries after enrollment.
- Primary aspects of beneficiary informing include:
  - Beneficiary handbook
  - Provider directory

Beneficiary Handbook

Counties are required to issue a beneficiary handbook to new enrollees. The beneficiary handbook must include:

- Benefits provided by the plan, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, and their amount, duration and scope.
- How and where to access any benefits, including any cost sharing, and how transportation is provided.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not provided by the plan or subcontractors
- The extent to which, and how, after-hours care is provided.
- Any restrictions on the beneficiary's freedom of choice among network providers.
- The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.
- Cost sharing, if any, is imposed under the State Plan.

Beneficiary Handbook

- Beneficiary rights and responsibilities, including:
  - The beneficiary's right to receive beneficiary and plan information; and
  - The elements outlined in the Beneficiary Rights and Protections section of the intergovernmental agreement.
- Grievance, appeal, and fair hearing procedures and timeframes
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries; and
- Information on how to report suspected fraud or abuse.

Beneficiary Handbook

The Beneficiary Handbook has the following sections:

- GENERAL INFORMATION
- SERVICES
- HOW TO GET DMC-ODS SERVICES
- HOW TO GET MENTAL HEALTH SERVICES
- MEDICAL NECESSITY
- SELECTING A PROVIDER
- NOTICE OF ADVERSE BENEFIT DETERMINATION
- PROBLEM RESOLUTION PROCESSES
- THE GRIEVANCE PROCESS
- THE APPEAL PROCESS
- THE STATE FAIR HEARING PROCESS
- IMPORTANT INFORMATION ABOUT THE STATE OF CALIFORNIA MEDI-CAL PROGRAM
- MEMBER RIGHTS AND RESPONSIBILITIES
- PROVIDER DIRECTORY

Beneficiary Handbook

- There will be an additional section for TRANSITION OF CARE added to the end of the handbook to comply with 42 CFR 438.62(b):

  (b) The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a MCO, PIHP, PAHP, PCCM or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM or PCCM entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

  (1) The transition of care policy must include the following:

  (i) The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the MCO, PIHP or PAHP network.

Beneficiary Handbook Resources

- Beneficiary Handbook requirements are outlined in the intergovernmental agreement.
- DHCS has a beneficiary handbook template that outlines all criteria required for the handbook.

Links to the IA and the beneficiary handbook can be found at the County Resources page on the DMCODS website.

Provider Directory

- Must be available in electronic form and paper form, upon request
- Provide information that is easily understood and readily accessible
- Electronic provider directories must be in a machine-readable format
- Be available in the prevalent non-English languages within the county
- Include taglines in the prevalent non-English languages in the State explaining the availability of free written translation or oral interpretation services to understand the information provided
- Use 12 point or larger font size for all text
- Include a large print tagline (18 point font or larger) and information on how to request auxiliary aids and services, including the provision of materials in alternative formats, at no cost to the beneficiary
- Include the Plan's 24-hour, toll-free beneficiary access line number, and TTY/TDY or California Relay Service telephone number

Provider Directory

The Provider Directory must contain the following information:

- The provider's name and group affiliation, if any
- Provider's business address(es)
- Telephone number(s)
- Email address(es), as appropriate
- Website URL, as appropriate
- Specialty
- Services / modalities provided, including information about populations served
- Whether the provider accepts new beneficiaries
- The provider's cultural capabilities
- The provider's linguistic capabilities including languages offered by the provider or a skilled medical interpreter at the provider's office; and
- Whether the provider's office / facility has accommodations for people with physical disabilities

Provider Directory

MHSUD IN 18-020

In addition to the information listed above, the provider directory must also include the following information for each rendering provider:

- Type of practitioner, as appropriate;
- National Provider Identifier number;
- California license number and type of license; and,
- An indication of whether the provider has completed cultural competence training

Plans may **choose** to delegate the requirement to list rendering provider information to network providers, but the following requirements must be met:

- The Plan must link the provider's website listing the above requirements to the Plan's website
- The provider's website must link to the Plan's website

Ultimately, it is the Plan's responsibility to monitor network provider's compliance with these requirements.

Provider Directory

- The Provider Directory must contain the following notation:

"Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

Provider Directory

Maintaining the Provider Directory

- The provider directory must be updated at least monthly
- Electronic provider directories located on the Plan's website must be updated within 30 days of receiving provider information
- Plans should have processes in place to allow providers to submit changes to the information in the directory.

Provider Directory Resources

- Federal guidance on required elements of a provider directory is available in IN 18-020.
- Intergovernmental Agreement: Exhibit A, Attachment I, II, B, 2, xv.

Grievances and Appeals

- Grievance and appeal procedures must be in place for all DMC-ODS beneficiaries and providers.
- Information Notice 18-010E
- Primary components of the grievance and appeal process include:
  - Notice of Grievance Resolution (NGRs)
  - Notice of Adverse Benefit Determination (NOABDs)
  - Notice of Appeal Resolution (NARs)

Reporting of Grievances and Appeals

- Plans must maintain a written record of grievances and appeals received, and log them with the following information:
  1. The date and time of receipt of the grievance or appeal;
  2. The name of the beneficiary filing the grievance or appeal;
  3. The name of the representative recording the grievance or appeal;
  4. A description of the complaint or problem;
  5. A description of the action taken by the plan or provider to investigate and resolve the grievance or appeal;
  6. The proposed resolution by the plan or provider;
  7. The name of the plan provider or staff responsible for resolving the grievance or appeal; and
  8. The date of notification to the beneficiary of the resolution.

- Plans must submit the record of grievances and appeals to their quality improvement committee quarterly, for aggregation and quality improvement analysis.
- Submitted to ODSSubmissions@dhcs.ca.gov

Notice of Grievance Resolution

- The 2016 managed care rule redefined the term “grievance” to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
- Plans must provide a written acknowledgement of the grievance, containing date of receipt, as well as the name, telephone number, and address of the plan representative who the beneficiary may contact about the grievance.
- Plans must also provide a written notice of grievance resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The template for the NGR is available here.

Notice of Adverse Benefit Determination (NOABD)

- The Final Rule replaced the term “Action” with “Adverse Benefit Determination.” An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:
  - The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
  - The reduction, suspension, or termination of a previously authorized service;
  - The denial, in whole or in part, of payment for a service;
  - The failure to provide services in a timely manner;
  - The failure to act within the required timeframes for standard resolution of grievances and appeals; or
  - The denial of a beneficiary’s request to dispute financial liability.

Notice of Adverse Benefit Determination (NOABD) Templates

Enclosure 2 **Denial Notice**

Used when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, this is also used for denied residential service requests.

Enclosure 3 **Payment Denial Notice**

Used when the Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.

Enclosure 4 **Delivery system notice**

Used 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. Note that this NOABD only applies to plans that also provide mental health services; for SUD only plans, this NOABD does not apply.

Notice of Adverse Benefit Determination (NOABD) Templates

Enclosure 5 **Modification Notice**

Used when the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

Enclosure 6 **Termination Notice**

Used when the Plan terminates, reduces, or suspends a previously authorized service.

Enclosure 15 **Timely Access Notice**

Used when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request.

Notice of Adverse Benefit Determination (NOABD) Templates

Enclosure 7 **Timely Access Notice**

Used when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

Enclosure 8 **Financial Liability Notice**

Used when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

Enclosure 16 **NOABD Grievance and Appeal Timely Resolution Notice**

Used when the Plan does not meet required timeframes for the standard resolution of grievances and appeals.

Notice of Appeal Resolution (NAR) Templates

Written NARs sent to beneficiaries must include the following:

a. The results of the resolution and the date it was completed;
b. The reasons for the plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
c. For appeals not resolved in the favor of the beneficiary, the right to request a state hearing and how to request it;
d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and,
e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the plan's adverse benefit determination.

Notice of Appeal Resolution (NAR) Templates

NAR templates include:

Enclosure 10 **Adverse Benefit Determination Upheld**

Used for appeals not resolved wholly in favor of the beneficiary

Enclosure 12 **Adverse Benefit Determination Overturned**

Used for appeals resolved wholly in favor of the beneficiary

“Your Rights” Documents—NOABD and NAR

Both NOABDs and NARs should come with a “your rights” document attached, which informs beneficiaries about their right to an appeal of a decision.

- Enclosure 9 NOABD “Your Rights” Attachment
- Enclosure 11 NAR “Your Rights” Attachment

Non-Discrimination and Language Assistance

- DHCS has created sample "Nondiscrimination Notice" and "Language Assistance" taglines, which are available for plan use. Plans may utilize the templates provided by DHCS, make modifications to the templates, or create new templates.
- These templates must be sent in conjunction with:
  - NOABD forms
  - Grievance acknowledgment letters
  - Appeal acknowledgment letters
  - Grievance resolution letters, and
  - NAR forms

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

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