Medi-Cal Managed Care Advisory Group
Written Responses to Stakeholder-Proposed Agenda Items
for September 7, 2017 Meeting

Requested Agenda Item
Monitoring of Prior Authorization for Dental Treatments **Request:** Enforcement of MCP Member Informing, Provider Training and P&P's. How member informing, provider training and policies and procedures outlined in the "Additional Information" of APL 07-008 (TOPICAL FLOURIDE VARNISH) are monitored and enforced: **http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2007/MMCDAPL07008.pdf.** **Response:** The Department of Health Care Services (DHCS) monitors Medi-Cal managed care health plan (MCP) compliance through a number of ways, including, but not limited to, review and approval of policies and procedures, annual audits, and conducting facility site reviews. Per APL 07-008, DHCS requires contracted MCP providers to timely document dental assessments and fluoride varnish applications in the member's medical record. Currently, documentation may be completed using the PM 160 form in the Child Health and Disability Prevention Confidential Screening/Billing Report. However, due to the phased discontinuation of the PM 160 form, DHCS will review impacted policies, including APL 07-008, and make updates as necessary.
Transition from MCP to MCP and Monitoring Access to Ensure Network Adequacy **Request:** Concerns have been raised from our advocates in the Central Valley regarding access to specialty care for clients who will be moved from Kaiser Medi-Cal to CalViva on September 1 during the transition. Please discuss how DHCS monitors specialty capacity, specifically for CalViva, and what the protections are in place for individuals moving from one MCP to another. **Response:** Members with pre-existing provider relationships who make a Continuity of Care (COC) request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network provider, in accordance with contractual guidelines.

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An MCP must file a Block Transfer with the Department of Managed Health Care (DMHC) at least 75 days prior to the termination or non-renewal of any provider contract with a provider group or a hospital. DMHC must review and approve the Block Transfer filing as well as the written notice the MCP proposes to send to affected members. DMHC will share the Block Transfer filing with DHCS. DHCS will review the approved Block Transfer decision and coordinate with MCPs regarding notification to, and transition of, affected members. Through the transition process, DHCS will continue to monitor to ensure all affected members receive proper access to care and continuity of care. Concerning the September 1 transition, DHCS required CalViva to make outreach calls to members who were potentially eligible for COC. CalViva completed all outreach calls, which required CalViva to make at least four attempts to connect with each member, as needed. Concurrently, CalViva was also required to send a written notice to the transitioning members, including those who had made a COC request. The COC notice informed transitioning members about the status of their request, in addition to providing them information about where, how, and when they would be able to receive services. The notice, which was approved by the Managed Care Operations Division, also provided resources for members seeking further assistance. The Managed Care Quality and Monitoring Division monitors through a variety of measures. On a quarterly basis, the network adequacy data is monitored and analyzed. The data is categorized into areas such as geographic access to specialists, out-of-network requests/referrals/denials, provider ratio, provider capacity, physical accessibility, access related grievances, and areas of quality concern. DHCS dialogues on a quarterly basis with the MCPs to ensure that all identified network concerns are appropriately addressed and corrected. If an MCP has exhausted all other reasonable options to obtain providers to meet either time and distance or timely access standards, the MCP can request an Alternative Access Standard from DHCS. If findings in a particular area continue to occur and remain unresolved, DHCS may impose a Corrective Action Plan or initiate enhanced monitoring.
New Prior Authorization Requirements for Gender Reassignment Surgery **<u>Request:</u>** Brownstein & Crane (one of the primary transgender-related surgery providers in the state) was told by Anthem Blue Cross Medi-Cal (Anthem) that the plan has new criteria for mental health clearance letters for transgender surgeries, specifically the criteria is not consistent with WPATH standards. Brownstein & Crane is now going down their appointment list for the next two years and rejecting patients whose mental health letters do not comply with Anthem's new

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policy and requesting that the patients get new ones. Attached is a letter from Brownstein & Crane that is being sent to patients. **Response:** DHCS conducted research and determined that Anthem requested that Brownstein & Crane cease dissemination of the request letter because it does not accurately reflect Anthem's policy. Anthem is currently working with Dr. Crane's office to discuss Anthem's criteria for mental health letters, and to provide the appropriate policy and member informing materials. In APL 16-013, DHCS clarified requirements for ensuring access to services for transgender members and for gender dysphoria treatments. APL 16-013 can be found here: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-013.pdf. Members should work directly with their MCP to understand how the MCP's policy meets DHCS requirements. If a member has a concern that the MCP's policies or procedures do not comply with APL 16-013, they should work directly with the MCP to resolve the issue. If unable to reach a resolution, the member should contact DHCS with specific examples of the issue and what occurred when attempting to resolve it with the MCP. Members may also exercise their rights to file a grievance or an appeal. If the member has already exhausted the MCP's internal appeal process, he/she may then request a State Fair Hearing, or request an Independent Medical Review for denied services.
Access Issue: Lack of In-Network OB/GYNs in Northern California **Request:** Could we talk about the multiple counties in the north that in the past had NO OB-GYN and how travel and distance are being addressed (if transportation to out of network providers is an element in those counties)? **Response:** DHCS reviewed the monthly provider file and found that there is adequate access to OB/GYN services in each county located in Northern California. Universal Requirement for Timely Access Standards All MCPs are contractually required to meet timely access standards. MCPs licensed under the Knox-Keene Act are required to meet the additional timely access standards contained in Title 28 California Code of Regulations (CCR), Section 1300.67.2.2. Therefore, if an MCP is unable to provide necessary services to a member, the MCP must provide these services out-of-network.

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DHCS conducts compliance audits and reviews of MCPs on an annual and triannual basis, depending on plan type, to determine the MCPs' compliance with state and federal requirements, including, but not limited to: network adequacy, provider monitoring, provider directories, and access standards. DHCS will enforce corrective action on any MCP that fails to meet network adequacy standards. DHCS has established processes to work with the MCPs on monitoring and oversight issues and when DHCS identifies that an MCP is struggling to meet network adequacy requirements, DHCS will provide technical assistance. However, if an MCP does not come into compliance with its corrective action plan, DHCS may impose a financial penalty or sanction. In order to strengthen DHCS' existing monitoring processes, DHCS will complete and submit an annual network certification to the Centers for Medicaid and Medicare Services (CMS). The network certification requirements are prescribed in Title 42, Part 438, of the Code of Federal Regulations. These requirements include verification of the following: network's ability to meet medically necessary services needed for the projected enrollment and utilization, number and types of network providers, geographic location of providers relating to time and distance and timely access, hours of operation, service availability, physical accessibility, out of network access, right to a second opinion, provider credentialing, and policy and procedure requirements such as continuity of care and provider compliance. DHCS will certify the networks with CMS annually and is required to make this documentation available to CMS upon request. <u>New Time and Distance Standards for OB/GYNs, Effective January 1, 2018</u> On April 25, 2016, CMS issued the Medicaid and CHIP Managed Care Final Rule (Final Rule). Final Rule Section 438.68 requires time and distance standards to be created for a variety of provider types, including OB/GYNs. In accordance with Final Rule, DHCS has created new time and distance standards for OB/GYNs, which will be implemented on January 1, 2018. The standard varies depending on whether the OB/GYN is reported as a PCP or as a specialist. The Final Rule added a new mandatory requirement to review the new network adequacy standards and validate MCP networks on an annual basis. The External Quality Review Organization (ERQO), an independent entity, will conduct these evaluations which include assessments of how an MCP is meeting access standards. DHCS is anticipating further details from CMS in a forthcoming EQR protocol. DHCS will include updates on monitoring in its annual program report to CMS, a separate and new requirement under the Final Rule. The report will contain any

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areas of concern related to network adequacy in addition to other required elements. Non-Medical Transportation (NMT) Services and Timely Access Standards A member's need for NMT and Non-Emergency Medical Transportation (NEMT) services does not relieve the MCP from complying with timely access standard requirements. MCPs must provide NMT services to members for any medically necessary covered services when the member's medical and physical condition is such that transportation by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. This information can be found in APL 17-010: **http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf.** Furthermore, each MCP is contractually required to notify its members of their rights concerning NMT by providing its members with a Member Services Guide that includes information on the procedures for obtaining NMT services, a description of NMT services, and the conditions under which NMT services are available. Alternative Access Standard If an MCP has exhausted all reasonable options to obtain providers to meet either time and distance or timely access standards, the MCP can request an Alternative Access Standard from DHCS.
Alternative Birth Centers (ABCs) and Midwife Choice **Request:** Could we discuss implementation of Alternative Birth Center and Midwife Choice for plans – do they all now have ABCs in their networks? **Response:** MCPs are contractually required to provide access to: • Certified Nurse Midwife (CNM) services, as defined in Title 22, CCR, Section 51345 • Certified Nurse Practitioner (CNP) services, as defined in Title 22, CCR, Section 51345.1 Additionally, each MCP must inform its members of their right to obtain out-of-network CNM services. If there are no CNMs or CNPs in the MCP's provider network, the MCP must reimburse out-of-network CNMs or CNPs at no less than the applicable Medi-Cal FFS rates.

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For birthing centers, whether alternative or freestanding, each MCP is required to reimburse no less than the applicable Medi-Cal FFS rates. Not all MCPs are currently contracted with available ABCs and/or Freestanding Birthing Centers. However, they are aware of this requirement and actively pursuing contracts.