Managed Care Quality and Access:

Medicaid Managed Care Final Rule Implementation

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MCHAP Meeting
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Presentation Outline

1. Monitoring Quality and Access
2. Medicaid Managed Care Final Rule
3. Proposed Network Adequacy Standards
4. Improved Beneficiary/Family Experience
5. Questions & Open Discussion

Monitoring Quality and Access

Elements of Plan Oversight

Regulations/Statutes

- Impose requirements on the State and managed care plans (MCPs) to promote quality of care, strengthen consumer protections, and improve program accountability.

MCP Contract

- DHCS binds the MCPs contractually to the regulatory and statutory requirements.

Plan Compliance

- MCPs must meet requirements to demonstrate compliance with contractual requirements (for example, plan readiness).

Corrective Action Plan (CAP) Process

- DHCS imposes a CAP when MCPs do not meet contractual requirements.

EQRO

Background

- DHCS contracts with the External Quality Review Organization (EQRO) to conduct external quality reviews and evaluate the care provided to beneficiaries in the areas of quality, access, and timeliness.
- MCPs collect HEDIS (Healthcare Effective Data and Information Set) data on measures, which include indicators known as the External Accountability Set (EAS).
- The EAS is a set of performance measures that DHCS selects for annual reporting by MCPs.

Focus Areas

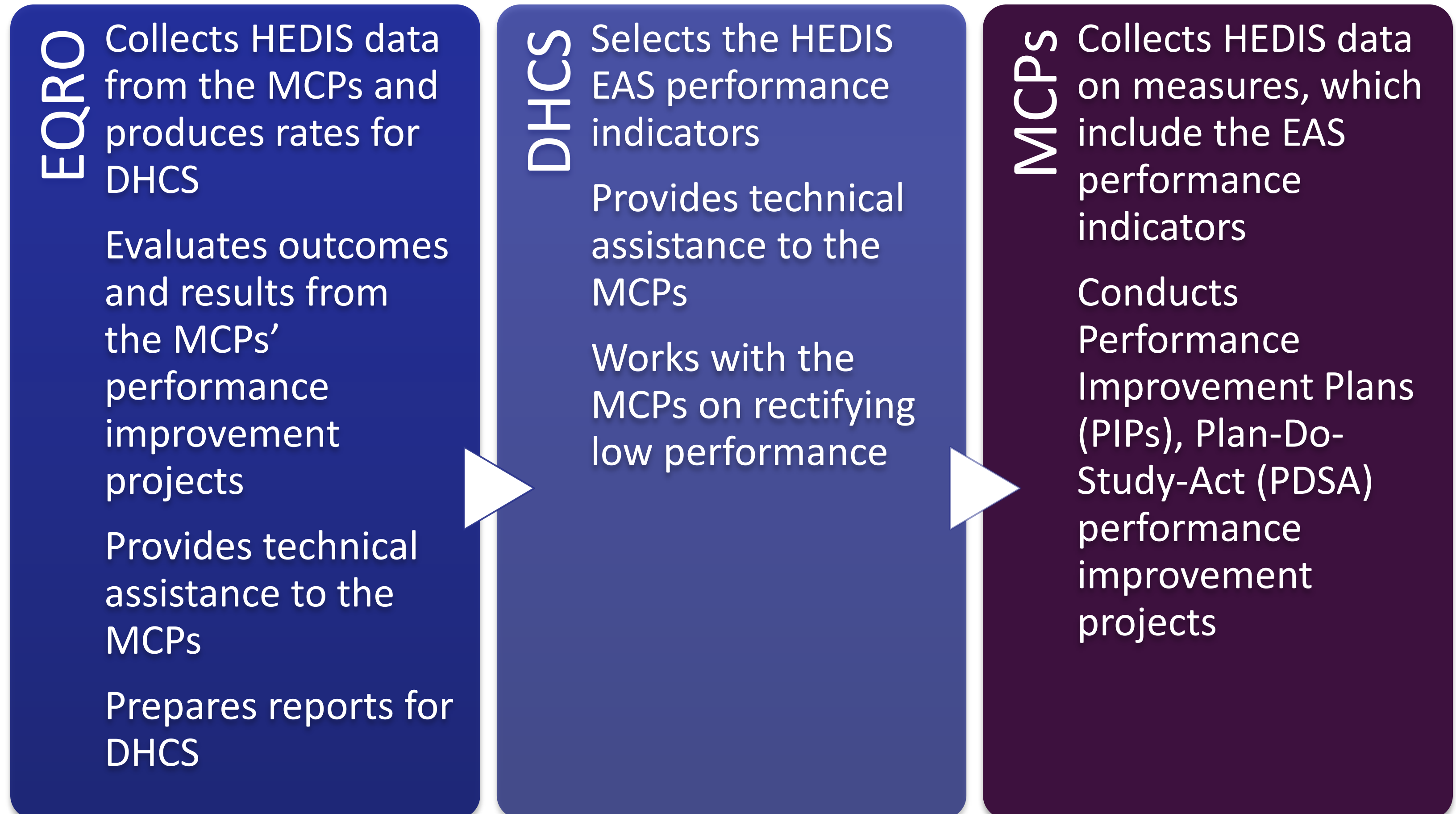
- The EAS focuses on three domains of care: quality of care, access to care, and timeliness of care.
- Other primary areas of focus include:
  - DHCS compliance audits related to access, structure, operational standards
  - EQRO validation of performance measures, performance improvement projects, and encounter data
  - EQRO-administered satisfaction surveys.

EQRO

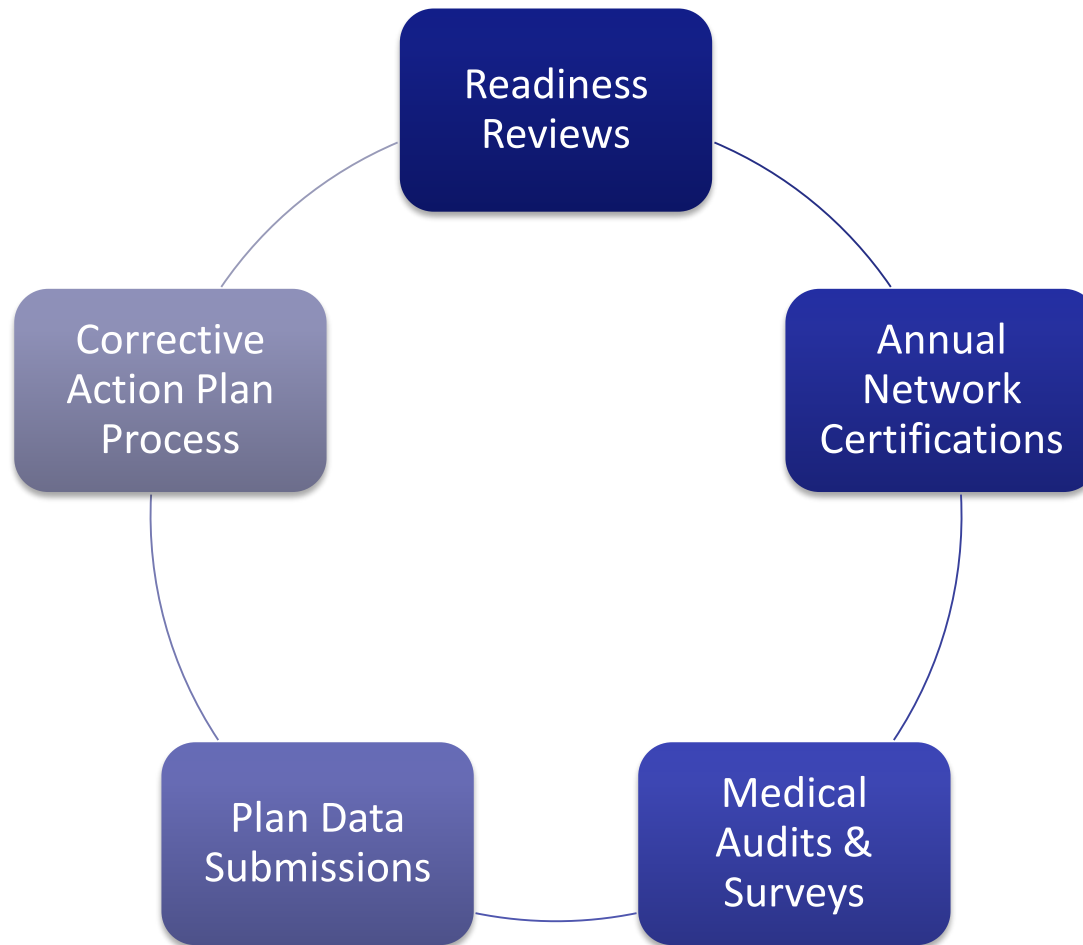
Other EQRO Activities

- Additionally, the EQRO and DHCS provide the MCPs with technical assistance to facilitate their ability to make continuous quality improvements.
- The EQRO presents these external quality review activities, results, and assessments in reports that help DHCS and Medi-Cal MCPs understand where to focus resources to further improve the quality of care.

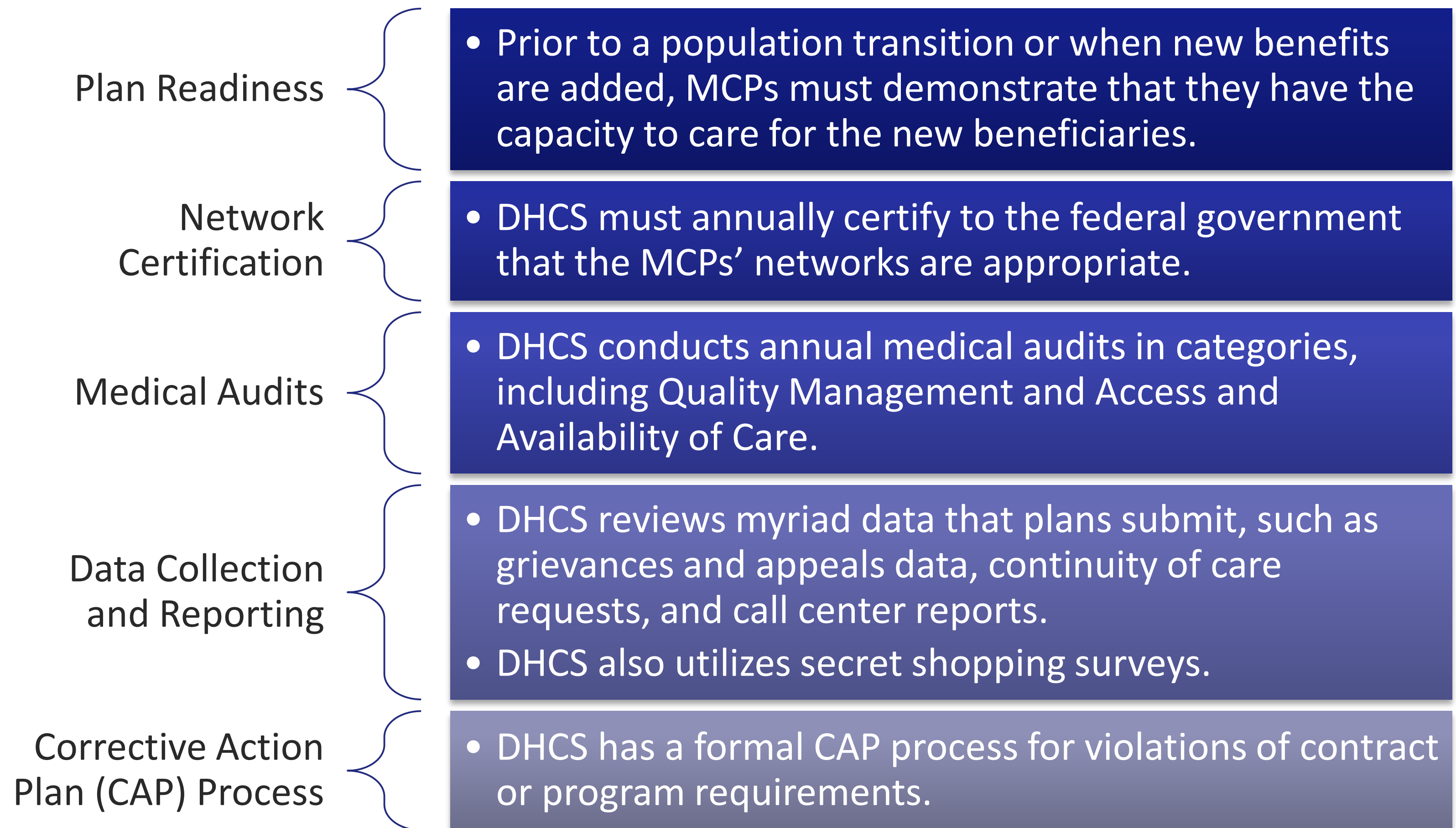
Quality Review



Network Adequacy Monitoring Elements



Monitoring Network Adequacy



Newly Added Monitoring Enhancements

Post-Adjudicated Claims and Encounters System (PACES)

- Implemented in 2015
- Receives all Medi-Cal managed care encounter data and provider network data
- Will soon allow MCPs to submit monthly provider network data files in a standard format known as the X12 274 Healthcare Provider Information Transaction Set, or 274 File

Benefits

- Supports Electronic Data Interchange (EDI), which allows transmission of data from the MCPs to DHCS with minimal need for human intervention
- Applies automated validation edits to 274 files immediately upon receipt, alleviating demand for staff resources and streamlining the data collection process

Medicaid Managed Care Final Rule

Final Rule Overview

Background

- First major overhaul of the managed care regulations since 2002
- Response to the major shift nationwide to the managed care delivery system
- Directed at states to ensure compliance with Medicaid MCPs and downstream effects to beneficiaries

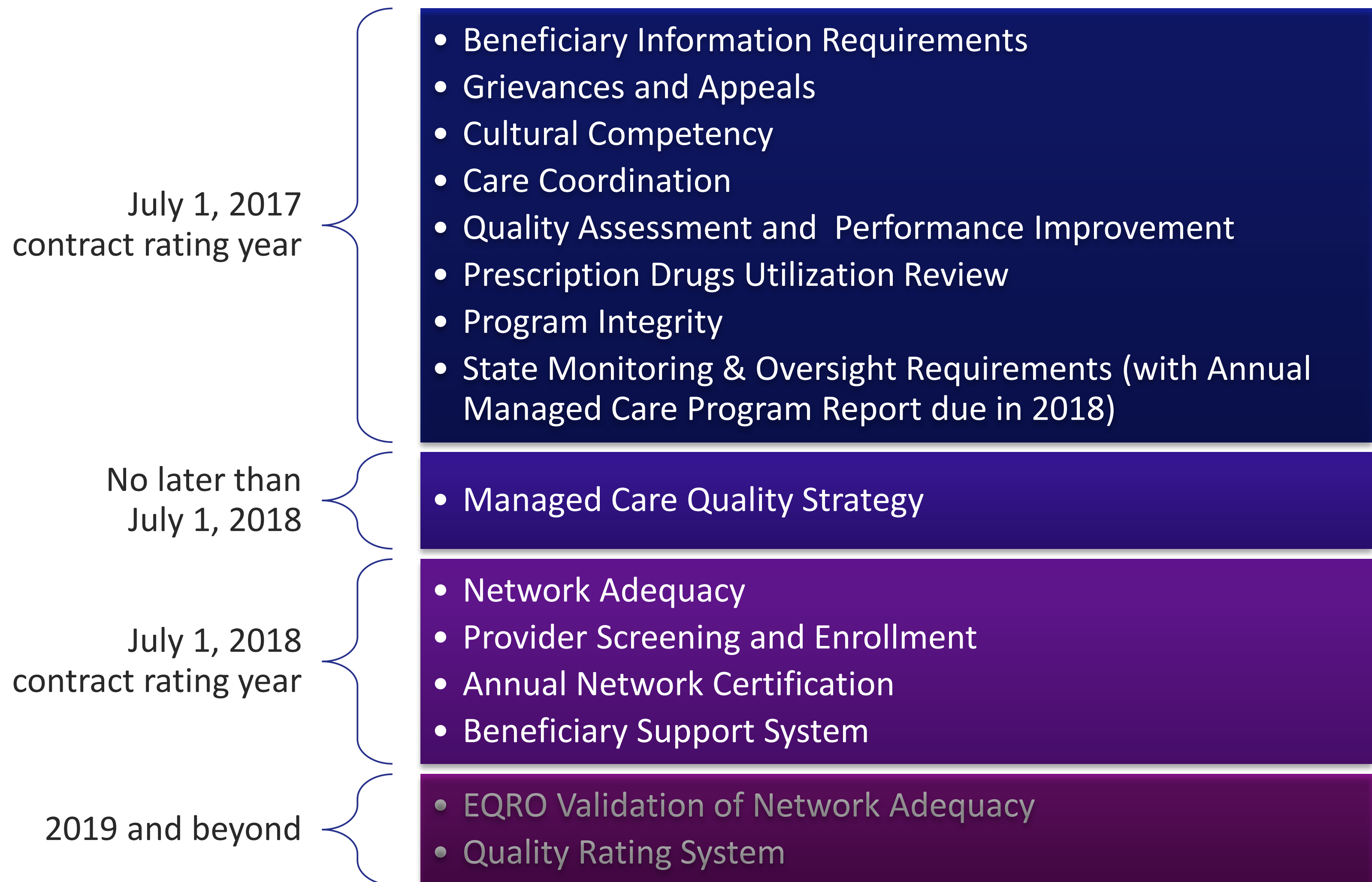
Recurring Themes

- Aligns the Medicaid managed care program with other health insurance coverage programs (i.e., Marketplace, Medicare Advantage)
- Adds many consumer protections to improve the quality of care and beneficiary experience
- Improves State accountability and transparency
- Inclusion of Long Term Services and Supports (LTSS) needs

Implementation Dates

- Effective July 5, 2016
- Phased implementation over three years, starting with the July 1, 2017 contract rating period

Major Provisions at a Glance



Network Adequacy Standards Development

Requirements

- The Final Rule set forth requirements but provided flexibility to states to develop the standards.
- The requirements expanded to additional provider types: Specialists, OB/GYN, behavioral health, pharmacy, pediatric dental, LTSS services that require the beneficiary to travel to the provider

California Approach

- Network adequacy standards exist in California today, which are established in Knox-Keene regulations and Medi-Cal contracts.
- In fact, DHCS' contractual standards for access and network adequacy are parallel to – and even exceed – what is required under the Knox-Keene Act.
- Most of our MCPs are regulated under the Knox-Keene Act; the COHS plans that are not Knox-Keene licensed are held to the same standards contractually.
- County mental health plans and County substance use disorder services through the 1115 Waiver have not had specific network adequacy standards, but are impacted under the Final Rule.

Rationale for Proposed Network Adequacy Standards

- Utilized existing standards that are available
- For provider types and services where there were no current standards, county population size was considered
- County population size groupings were based on the Department of Finance 2016 population data

Proposed Network Adequacy Standards

Primary and Specialty Care

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Primary care (adult and pediatric)	10 miles or 30 minutes from beneficiary's residence[2]	Within 10 business days to appointment from request[2]
Specialty care (adult and pediatric)	Based on county population size[1] as follows: Rural to Small Counties: 60 miles or 90 minutes from the beneficiary's residence Medium Counties: 30 miles or 60 minutes from the beneficiary's residence Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Within 15 business days to appointment from request[2]

[1] County size categories adopted and modified from the Department of Finance.
Rural to Small: <55,000 to 199,999; Medium: 200,000 to 3,999,999; Large: ≥ 4,000,000
[2] Requirement today

OB/GYN

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Obstetrics/ Gynecology (OB/GYN)	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care provider or specialist *Primary Care*: 10 miles or 30 minutes from beneficiary's residence[2] *Specialty Care* is based on county population size[1] as follows: Rural to Small Counties: 60 miles or 90 minutes from the beneficiary's residence Medium Counties: 30 miles or 60 minutes from the beneficiary's residence Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care provider or specialist *Primary Care*: Within 10 business days to appointment from request[2] *Specialty Care*: Within 15 business days to appointment from request[2]

Hospitals and Pharmacy

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Hospitals	15 miles or 30 minutes from beneficiary's residence[2]	
Pharmacy	Based on county population size[1] as follows: <u>Rural to Small Counties</u>: 60 miles or 90 minutes from the beneficiary's residence <u>Medium Counties</u>: 30 miles or 60 minutes from the beneficiary's residence <u>Large Counties</u>: 15 miles or 30 minutes from the beneficiary's residence	Request for prior authorization made via telecommunication: the greater of 24 hours or one business day response[2] Dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation[2]

Mental Health (Non-Physician)

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Mental Health (adult and pediatric)	Based on county population size[1] as follows: Rural to Small Counties: 60 miles or 90 minutes from the beneficiary's residence Medium Counties: 30 miles or 60 minutes from the beneficiary's residence Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request[2]

Substance Use Disorder Services

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Outpatient Services	Based on county population size[1] as follows: Rural to Small Counties: 60 miles or 90 minutes from the beneficiary's residence Medium Counties: 30 miles or 60 minutes from the beneficiary's residence Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request
Opioid Treatment Programs	Based on county population size[1] as follows: Rural to Small Counties: 30 miles or 45 minutes from the beneficiary's residence Medium Counties: 15 miles or 30 minutes from the beneficiary's residence Large Counties: 15 miles or 30 minutes from the beneficiary's residence	Within 3 business days to appointment from request

Pediatric Dental

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Pediatric Dental	10 miles or 30 minutes from beneficiary's residence[2]	*Routine appointment:* Within 4 weeks to appointment from the request[2] *Specialist appointment:* Within 30 business days to appointment from the authorized request[2]

LTSS

Provider Type	Time and Distance	Timely Access (Non-Urgent)
Skilled Nursing Facility (SNF)	None	Based on county population size[1] as follows: *Rural to Small Counties*: Within 14 business days of request *Medium Counties*: Within 7 business days of request *Large Counties*: Within 5 business days of request
Intermediate Care Facility (ICF)	None	Based on county population size[1] as follows: *Rural to Small Counties*: Within 14 business days of request *Medium Counties*: Within 7 business days of request *Large Counties*: Within 5 business days of request
Community-Based Adult Services (CBAS)	None	Capacity cannot decrease in aggregate statewide below April 2012 level[2]

Improved Beneficiary/Family Experience

Medi-Cal Ombudsman

Role of Ombudsman Today

- Serves as an objective resource to assist beneficiaries with plan concerns
- Recently consolidated Medi-Cal Ombudsman and Mental Health Services Ombudsman to better serve beneficiaries receiving services from the MCP and MHP
- Plan enrollment, disenrollment, and change of plans
- Help with access to care
- Help navigate the health care and mental health system
- Provide referrals to over 30 other entities including: Dental, Counties, other state departments, Social Security Administration, Coordinated Care Initiative Ombudsman, etc.
- Educate and inform beneficiaries

Expanding Role of Ombudsman in the Managed Care Final Rule

- Continue functions performed today, in addition to:
- Providing choice counseling
- Providing assistance for beneficiaries in understanding managed care and assistance for beneficiaries who use or receive LTSS

Beneficiary Support System

Expanding Role of Health Care Options (HCO)/Maximus

- As part of the Managed Care Final Rule, effective July 1, 2018, states are required to have a Beneficiary Support System (BSS) in place.
- DHCS is preparing its enrollment broker to meet the below requirements.

Purpose

- To assist existing and future beneficiaries understand the enrollment process and navigate their plan options

Components

- *Choice counseling* to provide enrollment assistance to beneficiaries when selecting a plan
- *Assistance for beneficiaries in understanding managed care*, such as help choosing a provider and navigating the system
- *Assistance for those who use LTSS*

Questions & Open Discussion