Network Assessments and Monitoring

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Medi-Cal Children’s Health Advisory Panel
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Presentation Overview

1. Network Adequacy Standards
2. Network Review Components
   - DHCS Medical Audits
   - DMHC Routine Medical Surveys
   - DHCS and DMHC Interagency Agreements (IA)
   - DHCS and DMHC Audit and Survey Coordination
   - Non-Routine Audits and Surveys
   - Corrective Action Plans
   - Other Monitoring Indicators
3. Plan Monitoring and Evaluation
Network Access Requirements

(1) Have **sufficient providers** to serve the enrollees

(2) Meet **service area needs** with the geographic distribution of primary care providers (PCP) and specialists

(3) Provide **timely access to care**

In order to have sufficient networks, health plans must:
# Primary Care Physician (PCP) Capacity

<table>
<thead>
<tr>
<th>Standard</th>
<th>1 PCP per 2,000 Enrollees</th>
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<tbody>
<tr>
<td>Authority:</td>
<td></td>
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<tr>
<td></td>
<td>▪ Title 28, 1300.51 (d)(G)(2)(H)</td>
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<tr>
<td></td>
<td>▪ Title 22 CCR Section 53853</td>
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<td></td>
<td>▪ DHCS Contract, Exhibit A, Attachment 6 – Provider Network</td>
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<tr>
<td>Plan Monitoring</td>
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<tr>
<td>and Evaluation:</td>
<td>✓ Readiness</td>
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<tr>
<td></td>
<td>▪ Full network certification submission to DHCS</td>
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<td></td>
<td>▪ Material Modification filing with DMHC</td>
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<td></td>
<td>▪ Deliverables submission per DHCS Contract, Exhibit A, Attachment 18 – Implementation Plan and Deliverables</td>
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<tr>
<td></td>
<td>✓ Contract Submission</td>
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<tr>
<td></td>
<td>▪ Quarterly Provider Network report</td>
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<td>✓ DMHC Medical Survey</td>
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<td>✓ Other Monitoring Indicators</td>
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</table>
## Physician Extenders Capacity

<table>
<thead>
<tr>
<th>Standard:</th>
<th>1 Physician Extender per 1,200 Enrollees</th>
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<tbody>
<tr>
<td>Authority:</td>
<td></td>
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</tbody>
</table>
| - Title 28, 1300.51 (d)(G)(2)(H)  
| - Title 22 CCR Section 53853(a)  
| - Welfare & Institutions Code Section 14182(c)(2)  
| - DHCS Contract, Exhibit A, Attachment 6 – Provider Network |

| Plan Monitoring and Evaluation: | ✓ Readiness  
| - Full network certification submission to DHCS  
| - Material Modification filing with DMHC  
| - Deliverables submission per DHCS contract, Exhibit A, Attachment 18 – Implementation Plan and Deliverables  
| ✓ Contract Submission  
| - Quarterly Provider Network report  
| ✓ DHCS Medical Audit  
| ✓ DMHC Medical Survey  
| ✓ Other Monitoring Indicators |
### Time and Distance Access

| Standard: | 15 miles/30 minutes (Title 28)  
10 miles/30 minutes (DHCS Contract) |
| Authority: | ▪ Title 28 CCR Rule 1300.51(d)(H)  
▪ DHCS Contract, Exhibit A, Attachment 6 – Provider Network |
| Plan Monitoring and Evaluation: | ☑ Readiness  
▪ Geo Access maps evaluation  
☑ Contract Submission  
▪ Quarterly Provider Network report  
☑ DHCS Medical Audit  
☑ DMHC Medical Survey  
☑ Other Monitoring Indicators |
# Timely Access

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standards</th>
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</thead>
<tbody>
<tr>
<td>Urgent care appointments that do not require prior authorization</td>
<td>48 hours</td>
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<tr>
<td>Urgent care appointment that do require prior authorization</td>
<td>96 hours</td>
</tr>
<tr>
<td>Non-urgent primary care appointments</td>
<td>10 business days</td>
</tr>
<tr>
<td>Non-urgent Specialist</td>
<td>15 business days</td>
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<tr>
<td>Non-urgent Mental health provider (non-physician)</td>
<td>10 business days</td>
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<tr>
<td>Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition</td>
<td>15 business days</td>
</tr>
<tr>
<td>Telephone Wait Times</td>
<td>Standards</td>
</tr>
<tr>
<td>Normal business hours</td>
<td>No more than 10 minutes</td>
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<tr>
<td>Triage – 24/7 services</td>
<td>24/7 services; Call back time of no more than 30 minutes</td>
</tr>
</tbody>
</table>
## Timely Access (continued)

| Authority: | ▪ Title 28 CCR Section 1300.67.2.2  
▪ DHCS Contract, Exhibit A, Attachment 9 – Access and Availability |
|------------|-------------------------------------------------------------------------------------------|
| Plan Monitoring and Evaluation: | ☑ DHCS Medical Audit  
☑ Other Monitoring Indicators  
▪ Grievances data  
▪ Call Center Reports data  
☑ CAHPS Survey results |
Component 1: DHCS Medical Audits

• Performed by the Audits and Investigations Division, Medical Review Branch

• Welfare and Institutions Code §14456

• Audits will be annual beginning in 2015
DHCS Medical Audit Categories

- Utilization Management
- Administrative and Organizational Capacity
- Medical Audit Categories
- Case Management and Coordination of Care
- Members Rights Quality Management
- Access and Availability of Care
Component 2: DMHC Medical Surveys

- Performed by the Department of Managed Health Care (DMHC)
- Knox-Keene Health Care Service Plan Act
- Conducted at least every three years

– Link to DMHC Medical Survey reports:
  [Link to DMHC Medical Survey reports](http://www.dmhc.ca.gov/LicensingandReporting/MedicalSurveys/SearchViewMedicalSurveyReports.aspx)
DMHC Medical Survey Categories

- Quality Management
  - Overall plan performance in meeting enrollees' health care needs
- Grievances and Appeals (member complaints)
- Medical Survey Categories
- Utilization Management (referrals and authorizations)
- Access and Availability
Component 3: DHCS/DMHC Interagency Agreements (IA)

Monitors the following transitions:
- Seniors and Persons with Disabilities (SPDs)
- Optional Targeted Low Income Children
- Rural Expansion
- Cal MediConnect

Each IA has three components:
- Financial Audit
- Network Adequacy Assessments
- Medical Survey
Component 4: Audit and Survey Coordination

- DHCS and DMHC have a joint audit schedule to coordinate DMHC Knox Keene and IA surveys and DHCS medical audits.
- Both auditing teams are on-site concurrently.
- Findings for the DMHC IA surveys and DHCS medical audits are consolidated during the Corrective Action Plan (CAP) process.
Component 5: Non-Routine Audits and Surveys

- DHCS and DMHC can also audit and/or survey a plan outside of the normal schedule for any reason.

- Conducted two times in 2014:
  - CalOptima
  - Alameda Alliance
Component 6: Corrective Action Plans (CAPs)

- DHCS Medi-Cal Managed Care Division, Plan Monitoring Unit, administers CAPs for:
  - DHCS Medical Audits
  - Interagency Agreement Surveys
  - Other non-scheduled audits or surveys

- A CAP response is required to be submitted to DHCS within 30 days of notification if any findings are present.

- DMHC also administers CAPs for routine medical surveys.
Component 7: Other Monitoring Indicators

1. Quarterly Grievances and Appeals Reports

2. Quarterly Reports
   - Medi-Cal Office of the Ombudsman Call Statistics
   - State Fair Hearings
   - DMHC Help Center Data
Component 7: Other Monitoring Indicators

4. Transition Data Submission Requirements

- Population-specific reporting for Seniors and Persons with Disabilities (SPDs), Optional Targeted Low Income Children (OTLIC), Rural Expansion, Low Income Health Plan (LIHP), and Cal MediConnect:
  - Grievance Report
  - Continuity of Care Report
  - Provider Network Additions and Deletions
  - PCP Assignment and Changes (Rural Expansion)
  - Consumer Satisfaction (Rural Expansion)
  - Fraud and Abuse (Rural Expansion)
  - Complaints and Resolution Tracking (Cal MediConnect)
Component 7:
Other Monitoring Indicators

5. Ongoing Data Submission Requirements

- Rural Expansion and Optional Targeted Low Income Children (OTLIC):
  - All Member Grievance Report
  - Detailed Provider Network Report
  - Continuity of Care Report
  - Grievance Log
  - Geo Access Report
  - Out of Network Report
  - Network Adequacy Report
Component 7: Other Monitoring Indicators

5. Ongoing Data Submission Requirements

- Seniors and Persons with Disabilities (SPDs):
  - Continuity of Care Report
  - Risk Stratification and Risk Assessment Data Report
  - SPD Grievance Report
  - Detailed Provider Network Report
  - Grievance Log
  - Geo Access Report
  - Out of Network Report
  - Network Adequacy Report
## Work in Progress and Future Endeavors

### Late 2014
- Finalized DHCS/DMHC joint response process for network findings
- Standardized Grievances & Appeals and Call Center reporting requirements to track data at the beneficiary level
- Implemented Timely Access Verification Studies

### Summer 2015
- Onboard new Network Adequacy/Monitoring Unit in the Managed Care Quality and Monitoring Division
- Implement the Network Adequacy Monitoring Project:
  - Incorporate encounter data into network monitoring
  - More robust data evaluation – State access mapping for alternate access standards, watch list, and provider panels
### Work in Progress and Future Endeavors

#### Ongoing

- Provide technical assistance to ameliorate poor performance
- Impose Corrective Action Plans (CAPs) for poor performance or not meeting contractual requirements
- Enforce sanctions when necessary
- Continue stakeholders/workgroup engagement
- Enhance Medi-Cal Managed Care Performance Dashboard