Medi-Cal Managed Care Advisory Group Meeting

December 13, 2018

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Agenda

- Welcome and Introductions
- Updates
  - Transitions and Implementations
    - Whole Person Care
    - Health Homes
    - Diabetes Prevention Program
  - Timely Access
  - Ombudsman Report
  - RFP Timeline
  - Sanctions
- Annual Network Certification Updates
- Medical Audits Process Overview
- Status on All Plan Letters and Dual Plan Letters
- Open Discussion
- Next Meeting

Welcome and Introductions

Brian Keefer, Chief
Plan Oversight Section
Program Monitoring and Compliance Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Transitions and Implementations

Whole Person Care

Oksana Meyer, Chief
Coordinated Care Programs Section
Managed Care Quality and Monitoring Division
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Transitions and Implementations

Health Homes Program

Oksana Meyer, Chief
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Transitions and Implementations

Diabetes Prevention Program (DPP)

Dana Durham, Chief
Policy and Medical Monitoring Branch
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Department of Health Care Services

Timely Access

Brian Keefer, Chief
Plan Oversight Section
Managed Care Quality and Monitoring Division
Department of Health Care Services

Ombudsman Report

Michelle Retke, Chief
Managed Care Systems & Support Branch
Managed Care Operations Division
Department of Health Care Services

RFP Timeline

Michelle Retke, Chief
Managed Care Systems & Support Branch
Managed Care Operations Division
Department of Health Care Services

Sanctions

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Annual Network Certification (ANC) Updates

Managed Care Quality and Monitoring Division
Mental Health Services Division
Substance Use Disorder – Program, Policy, and Fiscal Division
Medi-Cal Dental Services Division
Department of Health Care Services

ANC Panel

Managed Care

Cortney Maslyn, Health Program Specialist I
Managed Care Quality & Monitoring Division
Department of Health Care Services

Network Certification APL

- Network Certification Requirements APL and its attachments are out for comment
- Significant Revisions Additions to the APL include:
  - Revised Network Certification submission and review process
  - Aligned policy guidance with other APLs
  - Added Timely Access as an ANC component
  - Added Provider Validations as monitoring mechanism
  - Detailed Pre Corrective Action Plan (CAP) and CAP process along with associated mandates

ANC Panel

Managed Care:
Corrective Action Plans (CAPs)

Hannah Robins, Chief, Compliance Unit
Cassandra Lashmett, Network Adequacy Unit
Brian Keefer, Chief, Plan Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Temporary Network Standard and Other Requirements

- **Out-of-network access**
  - Plans under a CAP are deemed in compliance with an approved temporary standard that requires authorization for out-of-network services within the timely access standards.
- **Member services training**
  - All Plan member services staff who provide information to members for appointments or process authorization requests (including those of subcontractors) are aware of and trained on processing appointments including out-of-network access.
- **Enhanced monitoring**
  - The External Quality Review Organization (EQRO) will conduct a timely access survey to ensure compliance with timely access to appointment standards.
  - DHCS will review Plan training materials and call center scripts in addition to completing an out-of-network survey to ensure all requirements are being met.

CAP Process

- Plans that did not meet the certification requirements had a Network Adequacy Corrective Action Plan (CAP) imposed.
- A total of 9 plans received a CAP:
  1. Aetna
  2. Anthem (CAP closed 9/26/18)
  3. California Health and Wellness
  4. Care 1st (CAP closed 9/26/18)
  5. Central California Alliance for Health (CAP closed 9/26/18)
  6. Inland Empire Health Plan (CAP closed 7/18/18)
  7. Health Net
  8. L.A. Care (CAP closed 7/13/18)
  9. United Healthcare (CAP closed 9/26/18)
- Plans have 6 months (until 1/8/19) to rectify the deficiencies and come into compliance.
- If the CAP deadline is not met, DHCS has the option to impose additional compliance actions as needed, such as sanctions.

ANC Panel

Managed Care:
Alternative Access Standards (AAS)

Cassandra Lashmett, Chief
Network Adequacy Unit
Managed Care Quality & Monitoring Division
Department of Health Care Services

Alternative Access Review

Approach

- MCPs unable to meet time and distance standards for assigned members submitted AAS requests when they have exhausted all other reasonable options for contracting with providers in order to meet the applicable standards.
- MCPs submitted AAS requests following a DHCS reporting template provided to the MCPs. MCP AAS requests were organized by zip code and county and included:
  - Driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote members;
  - Three nearest out-of-network providers
  - Proposed AAS standard in minutes and miles from the most remote members and
  - MCPs contracting efforts

Alternative Access Review cont.

Methodology

- DHCS reviewed the requests for AAS and approved or denied each request on a zip code and provider type basis using the following review criteria:
  - Driving times to the nearest in-network provider request that exceeds the time standard
  - Distance to the nearest in-network provider that exceeds the distance standard
  - Name and address of closest in-network provider
  - Names and addresses of three closest provider;
  - Narrative explaining why the plan was unable to execute contract with located provider, to include if there was a rate dispute between the provider and MCP
  - Determined whether the proposed alternative standard is a reasonable request based on DHCS data sources
  - DHCS considered the geographic region, size, and total members affected when reviewing the request
- DHCS approved AAS requests are valid for one contract year and must be resubmitted to DHCS for approval annually.

Alternative Access Standard

- Over 18,000 AAS Requests decisions have been made based on different criteria:
  - MCPs serving geographically remote regions primarily for specialists.
  - MCPs requested alternative time and distance standards for specialists, more specifically for pediatric specialists in both rural and urban counties.
  - MCPs serving members within same zip code also requested AAS. Providers in a similar zip code contract with only one plan and not the other, resulting in the MCP unable to contract with nearest provider.
- <1,000 AAS requests are currently under review:
  - Requests continue to be submitted due to the CAP. DHCS continues to provide technical assistance to ensure all requests are reviewed regardless of submission date.
  - MCPs can submit AAS on an ongoing basis.

Public Reporting

- DHCS will post on the website:
  - Letter to CMS - Attestation of network certification compliance
  - Network Certification Results - Assurance of Compliance document
  - Approved Alternative Access Standards
  - CAP findings and Plan responses

Questions/Comments

ANC Panel

Specialty Mental Health Services (SMHS)

Autumn Boylan, Chief
Program Monitoring and Compliance Branch
Mental Health Services Division
Department of Health Care Services

Specialty Mental Health Network Certification

- **County Information Notice**
  - Mental Health and Substance Use Disorder Services Information Notice 18-011

- **MHP Reporting Requirements**
  - Network provider data reported for each organization, site and rendering provider
  - Geographic Access Maps
  - Expected utilization of SMHS
  - Alternative Access Standards
  - American Indian Health Facilities
  - Supporting documentation, including: language line utilization, grievances, and policies & procedures

SMHS Annual Network Certification

Network Certification Components

- Time and Distance Standards – Geographic Access Maps
- Provider Composition and Capacity
- Mandatory Provider Types – American Indian Health Facilities
- Language Capacity
- Network Infrastructure

Alternative Access Standards

- Alternative Access Standards for 4 MHPs (17 total approved AAS)

MHP Results

28 MHPs passed all five review components

28 MHPs conditionally passed (in one or more areas) and were under a Corrective Action Plan (CAP)

Review Component	# MHPs Pass Psychiatry (Adults)	# MHPs Pass Psychiatry (Children)	# MHPs Pass OP SMHS (Adults)	# MHPs Pass OP SMHS (Children)
Time and Distance Standards – Geographic Access Maps	55/56	55/56	56/56	56/56
Provider Composition and Capacity (Ratio)	44/56	44/56	51/56	42/56

Review Component	Pass	Conditional Pass	Other
American Indian Health Facilities	25	9	31
Language Capacity	51	5	N/A
Infrastructure	52	4	N/A

Corrective Action Plans

- MHPs that did not meet the certification requirements had a Network Adequacy corrective action plan (CAP) imposed.
- An MHP under a CAP must adequately and timely cover SMHS services out-of-network for its beneficiaries.
  - The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.
- DHCS monitors the Plan's corrective actions and requires updated information from the MHP on a monthly basis (until the CAP is complete).
- MHP CAPs must be completed by December 31, 2018. If not completed, the MHP is subject to enhanced monitoring.

Out-of-Network Access

- MHPs under a CAP must adequately and timely cover SMHS services out-of-network for its beneficiaries.
- The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.

Out-of-Network Access

- The MHP's CAP must address procedures for ensuring beneficiaries are informed and have access to out-of-network providers.
- The MHP's CAP must also include the provision of training to its 24/7 Access line staff, and other front line staff, who provide information to beneficiaries regarding appointments, as well as any staff responsible for processing authorization requests (including those of subcontractors), to ensure staff who interact with beneficiaries are aware of and trained on processing appointments including out-of-network access.
- The MHP must submit training materials and call center scripts, as applicable, as part of the MHP's CAP.

DHCS Public Reporting

- DHCS posted on the website:
  - Letter to CMS - Attestation of network certification compliance
  - Network Certification Results - Assurance of Compliance document
  - Approved Alternative Access Standards
  - CAP findings and Plan responses

http://www.dhcs.ca.gov/services/Pages/Mental-Health-Plan-Final-Rule-and-Parity-Information.aspx

Questions/Comments

ANC Panel

Drug Medi-Cal Organized Delivery System (DMC-ODS) Network Certification

Marco Zolow, Health Program Specialist II
Substance Use Disorder – Program, Policy, and Fiscal Division
Department of Health Care Services

Drug Medi-Cal organized Delivery System (DMC-ODS)

- DMC-ODS Plans in operation prior to July 1, 2017 required certification.
  - Riverside, Marin, San Mateo, Santa Clara, Contra Costa, and San Francisco counties were certified.
  - Time and distance standards included outpatient substance use disorder services and opioid treatment services.
  - Guidance was provided in march 22, 2018 DHCS webinar and in Mental Health and Substance Use Disorders Information Notice 18-011.

Network Certification Components

- Plans were required to submit:
  - Completed Network Adequacy Certification Tool
  - Alternative Access Requests
  - Geographic Access Maps
  - Grievances and appeals related to access
  - Multiple policies and procedures
  - Language line utilization
  - Provider agreements and subcontracts

Network Certification Approach

- Data Validation and Analysis:
  - Utilized various data sources (e.g., claims data, enrollment data, eligibility data, provider files) to validate county data submissions.
  - Analyzed Plans' infrastructure through review of supporting documentation.
  - Validated geographic maps.
  - Reviewed Alternative Access Requests.

DMC-ODS Results

- San Mateo, Riverside and Contra Costa submitted Alternative Access Requests.
- Six plans met the Annual Network Adequacy requirements with a conditional pass due to identified deficiencies.
- CAP notices were sent out on July 2, 2018 for deficiencies noted during supporting documentation analysis.
- Plans have submitted their CAPs and are working toward resolving the deficiencies.

Questions/Comments

ANC Panel

Dental Managed Care

Kate Agyeman, Chief
Jeanette Fong, Health Program Specialist II
Dental Managed Care Unit
Medi-Cal Dental Services Division
Department of Health Care Services

DMC Counties Served

- **2 DMC Counties:**
    1. Sacramento – mandatory
    2. Los Angeles – optional

- **3 Contracted DMC Plans:**
    1. Access Dental Plan – both counties
    2. Health Net of California – both counties
    3. Liberty Dental Plan – both counties

Projected Enrollment

- DHCS reviewed enrollment trends from the previous three fiscal years and assumed that enrollment within DMC plans would remain consistent with these trends.

	Sacramento	Los Angeles
Access	136,500	176,604
Health Net	129,289	189,506
Liberty	162,191	64,306
TOTAL	427,980	430,416

Enrollment as of 02/02/18

Network Capacity

- **Provider-to-Member Ratios**
  - Primary Care Dentists (PCD) = 1:2000
  - Total Dentist = 1:1200

- All plans' reported provider networks met and far exceeded the required provider to member ratios. Networks would still have the capacity to serve members even with a substantial increase in projected enrollment.

- DHCS validated plans' reported provider networks by surveying a random sample of providers.

Specialist Network

- **No Mandated Requirement for Specialist Counts**

  However, the following specialist types were incorporated into the total provider count when determining compliance with required total dentist to member ratio (1:1200):

  - Endodontists
  - Oral Surgeons
  - Orthodontists
  - Pedodontists
  - Periodontists
  - Prosthodontists

- DHCS still evaluated the specialist network for each plan and determined that plans have an adequate network to ensure access to specialty services.

Geographic Distribution

- **Time & Distance Standards**
  - PCD (adults) = 10 miles or 30 minutes
  - PCD (children) = 10 miles or 30 minutes
- DHCS utilized Geographic Information Systems (GIS) software to validate the geographic distribution of PCD provider networks separately for both adults and children.
- CAPs were issued to all 3 plans for not meeting the required standard in 2-3 remote zip codes.
- CAPs have since been closed on 10/17/18.
- Alternate Access Standards (AAS) were approved in 3 zip codes.

Timely Access

- **Timely Access Standards (Appointments)**
  - Initial, Routine, and Preventive Care = 4 weeks
  - Specialists (adults) = 30 business days
  - Specialists (children) = 30 calendar days
  - Emergency = 24 hours

- CAPs were issued to Health Net and Liberty for not being able to substantiate timely access to specialist appointments. Plans were not conducting follow-up with providers who were non-responsive to surveys.

- CAPs have since been closed on 9/17/18.

- DHCS also validated providers' reported timely access to appointments by surveying a random sample of providers for a all appointment types and found plans to be compliant.

Questions/Comments

Medical Audits Process Overview

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Medical Review Branch
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Luis Galvez, Chief
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Status on APLs and DPLs

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All Plan Letters (APLs)

Letter Number	Title and Description of Letter	Date of Issue
APL 18 014 **Supersedes** **APL 17 016**	Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care This APL aligns with the April 2018 updates to the Preventive Services Medi-Cal Provider Manual and provides a more detailed description of what may be included in behavioral counseling interventions.	09/14/2018
APL 18 015 **Supersedes** **APL 13 018**	Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans Instructs MCPs on using the MOU to ensure care coordination for members enrolled in Health Homes who also receive care through a mental health plan.	09/19/2018
APL 18 016 **Supersedes** **APL 11 018**	Readability and Suitability of Written Health Education Materials Informs all MCPs of updated requirements for reviewing and approving written health education materials. Includes the following updated attachments: • Document A: Definitions and Requirements • Document B: Readability and Suitability Checklist for Written Health Education Materials	10/5/2018
APL 18 017 **Supersedes** **PL 02 01**	Blood Lead Screening of Young Children Clarifies blood lead screening and reporting requirements for Medi-Cal managed care health plans.	10/22/2018
APL 18 018	Diabetes Prevention Program This APL establishes the Diabetes Prevention Program, a program designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes.	11/16/2018

Dual Plan Letters (DPLs)

Letter Number	Title and Description of Letter	Date of Issue
DPL 18 003 **Supersedes** **DPL 13 006**	Care Plan Option Services Clarifies policy and requirements for Care Plan Option (CPO) services. Explains the difference between the Long-Term Services and Supports that a Cal MediConnect plan must offer as part of Medi-Cal and the optional services, like CPOs, that a Cal MediConnect plan may offer.	11/20/18

Open Discussion

Next Meeting is scheduled on
March 7, 2019

For questions, comments or to request future agenda items please email MCQMD@DHCS.ca.gov.