Medi-Cal Managed Care Advisory Group (MCAG)
Written Responses to Stakeholder Proposed Agenda Items
from the December 13, 2018, Meeting

Topic	Written Response
Dental Care, Assembly Bill (AB) 2207 Requesting a discussion on the guidance that Medi-Cal managed care health plans (MCPs) have received about provisions to do the following: An MCP must: (1) Provide dental screenings for every eligible beneficiary as a part of the beneficiary's initial health assessment. (2) Ensure that an eligible beneficiary is referred to an appropriate Medi-Cal dental provider. (3) Identify plan liaisons available to dental managed care contractors and dental fee-for-service contractors to assist with referrals to health plan covered services Children Now's understanding from a 2016 meeting with Dr. Anna Lee Amarnath and Dana Durham from Managed Care Quality Monitoring Division (MCQMD) is that Memorandum of Understanding (MOUs) regarding dental care coordination were to be developed between MCPs and Child, Health and Disability Prevention (CHDP) programs at the county level. In addition to the guidance that has been provided to MCPs, we also request a status update on any MOUs that have been filed with DHCS.	**Department of Health Care Services (DHCS) Response:** DHCS is currently preparing a presentation on CHDP and care coordination for an upcoming meeting. Please regularly check the MCAG webpage for future meeting dates. The MCAG webpage can be found here.

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CHDP/Managed Care Guidance Regarding the interaction of CHDP and managed care, has DHCS provided sufficient guidance to the MCPs about their role within care coordination and provider education?	**DHCS Response:** Please refer to the response above.
Medi-Cal 2020 Waiver Access Assessment Please provide an update on the recently approved Medi-Cal 2020 Waiver Access Assessment; specifically when should results be expected given the delayed approval by Centers for Medicare & Medicaid Services?	**DHCS Response:** DHCS will continue to follow the time frame as written in the Special Terms & Conditions (STCs) on Access Assessment (Section IX.A. pp.47-50). In accordance to the timeline found in the STCs, DHCS has submitted data to its External Accountability Review Organization, Health Service Advisory Group (HSAG), for review. HSAG is currently analyzing the data and will produce an initial draft report. DHCS will post the initial draft report for a thirty (30) day public comment period no later than ten months after CMS approved the assessment design. For more information, please refer to the STCs here.

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Proposition 56 Please provide an update on the status of the Proposition 56 rate increases for well-child visits approved in the 2018-19 budget. What is DHCS doing to educate and promote providers and MCPs about the rate increases? How is DHCS planning to measure or evaluate the impact of the well-child rate increases? Update on Prop. 56 Physician and Dental Supplemental Payments - Have increased rates lead to improvements in access to care?	**DHCS Response:** DHCS is actively working on presenting an update on Proposition 56: Physician and Dental Supplemental Payments. An update will be available at a forthcoming meeting.
Delegated Entities Update on Delegated Entities - Please provide an update on DHCS and MCP's efforts to improve oversight over delegated entities.	**DHCS Response:** DHCS is currently reviewing policy on the oversight of subcontractors and delegated entities. DHCS expects to publish updated guidance at a future date.

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Transportation to Carved-Out Services	**DHCS Response:**
Can DHCS discuss MCP's duty to coordinate transportation to carved-out services? How is this communicated? What is the MCP authorization process and how does it differ for carved-in services, if at all?	MCPs are required to establish policies and procedures for members to obtain medically necessary Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. MCPs must make their best effort to refer and coordinate NEMT services not covered under the MCP's contract, and MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP's contract. Members are notified of these benefits through the MCP's Evidence of Coverage which outlines the differences between the transportation types and how to request the services. MCPs are only required to have authorization processes for NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization. MCPs must use a DHCS approved Physician Certification Statement form to determine the appropriate level of NEMT for members. Per APL 17-010, MCPs must authorize, at a minimum, the lowest cost type of NEMT that is adequate for the member's medical needs. Furthermore, MCPs may implement prior authorization processes for approving NMT services and reauthorize services every 12 months when necessary. NEMT is only available for carved-in benefits. NMT does not require any prior authorization and is available for all services, including carved-out benefits. There are other requirements for a member to be eligible for NMT which is outlined in APL 17-010.

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	In addition to APL 17-010 being released, DHCS has also held a Transportation Workgroup and developed Frequently Asked Questions based on the outcome of the workgroup. DHCS continues to discuss the policy with key stakeholders and will continue to communicate changes as necessary.

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Senate Bill (SB) 1287 Implementation Update Will there be a provider bulletin or other guidance coming on SB 1287?	**DHCS Response:** DHCS expects to release updates to the provider manual in late spring 2019. An updated provider bulletin will be released at the time of publication. The Preventative Services section was recently updated in February 2019 to include the Bright Futures and American Academy of Pediatrics' periodicity schedule for preventative and screening services for children and youth up to 21 years of age. The periodicity schedule now specifies the codes to use for various parts of the schedule. Additionally, the preventative service visits were expanded so beneficiaries are able to access preventative visits once per calendar year instead of one visit every 365 days. The updates to the Preventative Services section can be found here.
External Accountability Set (EAS) Measures Update on the timing of EAS measures workgroup.	**DHCS Response:** DHCS presented on EAS measures at the March 2019 MCAG meeting. Please refer to the March 2019 meeting notes when they become available. All past meeting notes can be found on the MCAG Archives webpage here.

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Proposition 56 Update on Prop. 56 Physician and Dental Supplemental Payments - Have increased rates lead to improvements in access to care?	**DHCS Response:** For the Medi-Cal dental program, DHCS does not have data available for Prop 56 Fiscal Year (FY) 18-19. The following results use utilization across FY 16-17 and 17-18 as the metric. Overall total procedures and beneficiary counts for FY 16-17 and FY 17-18 are as follows: • Total Procedures for FY 16-17: 11,688,363 • Total Procedures for FY 17-18: 11,955,268, an increase of 2.3% • Top 10 performing counties based on percentage change of number of procedures are Modoc (57%), Humboldt (45%), Contra Costa (33%), Placer (28%), Lassen (26%), Colusa (22%), Yolo (20%), Butte (18%), San Mateo (16%), and Solano (15%). • Total Beneficiaries for FY 16-17: 7,459,194 • Total Beneficiaries for FY 17-18: 7,741,120, an increase of 3.8% It is important to note that in FY 17-18, the supplemental payments were set at 40% above the Schedule of Maximum Allowances (SMAs) of certain procedure codes. In FY 18-19, DHCS expanded the scope to include the top 25 most utilized dental procedures, and set the supplemental payments at different amounts for certain codes (e.g., 20%, 40%, 60% or dollar amount increases) above the SMA.

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Provider Enrollment In reference to network adequacy, are there challenges finding and/or certifying providers that are contributing to the inability to meet network adequacy standards in some areas and if so, what are those challenges?	**DHCS Response:** During the 2018 ANC, all MCPs met network standards, while those under a Correction Action Plan (CAP) for time and distance emerged from the CAP. Consequently, provider enrollment and certification issues or challenges that may have occurred did not impact the ability for MCPs to demonstrate they have a sufficient and adequate network of providers. However, the comment is appreciated and DHCS will be looking to see impacts going forward now that provider enrollment is a policy that is fully implemented statewide and being an enrolled provider is a condition for being considered a network provider.