Department of Health Care Services (DHCS)
Managed Care Advisory Group
Meeting Notes
December 7, 2017

1. Introductions

Hannah Robins, Acting Chief, Managed Care Operations Unit, Managed Care Quality and Monitoring Division (MCQMD) called the Managed Care Advisory Group (MCAG) meeting to order at 10:05 a.m. and welcomed all in attendance including those on the webinar.

2. Quality Efforts in Family Planning Panel Discussion

The Department of Health Care Services and San Francisco Health Plan presented on quality efforts in family planning.

Department of Health Care Services

Liane Winter, Health Program Specialist I, Office of the Medical Director, provided an update on DHCS' ongoing efforts for improving maternity care. In California, childbirth is the top reason for hospitalizations, in which half of those hospitalized due to childbirth are Medi-Cal members. Women enrolled in Medi-Cal are more likely to have inadequate prenatal care, less likely to attend postpartum visits, breastfeed, and receive influenza vaccinations.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME) focuses on increasing access to coordinated primary care improvements in perinatal care. PRIME project goals include a collaboration with national and statewide partners to decrease morbidity and mortality, promoting vaginal births, breastfeeding, and ensuring access to outpatient care. PRIME hospitals are improving maternal care and outcomes by utilizing innovative ways to engage patients and families to better inform their maternity care.

DHCS' presentation may be found here.

San Francisco Health Plan

Jim Glauber, Chief Medical Officer, San Francisco Health Plan (SFHP), gave a high-level overview of contraceptives and their telemedicine department.

SFHP has collaborated with Teladoc to provide telemedicine access for members. Teladoc currently provides video and telephonic visits with a doctor, with an average wait time of 8 minutes. While Teladoc will not replace a member's primary care physician or specialist, it provides a different method for a member to contact a physician.

SFHP's presentation may be found here.

3. Updates

Palliative Care

Monica Handley, Health Program Specialist I, MCQMD, provided an update on DHCS' ongoing implementation of palliative care. The palliative care policy consists of patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The policy focuses on congestive heart failure, cancer, liver disease and chronic obstructive pulmonary disease.

Palliative care benefits include:

- Advanced care planning
- Assessment and consultation
- Planning of care
- Care coordination
- Pain and symptom management
- Mental health and medical social services

The palliative care benefit implementation date is January 1, 2018. Additional information on palliative care was published on October 19, 2017 with All Plan Letter (APL) 17-015.

DHCS' presentation may be found here.

Timely Access Survey

Jennifer Janos, Chief, External Quality Review Organization (EQRO) Contract Management Unit, MCQMD, provided an update on DHCS' efforts to improve timely access surveying and monitoring. Past surveys were conducted once a year for non-urgent appointments with sample sizes less than 40. The new survey process includes quarterly surveys that focus on the first three available urgent and non-urgent appointments. Surveying is set to begin Quarter 1 of CY2018. Provider categories include primary care, specialty care, prenatal care, non-physician mental health care, and ancillary providers. The survey sample size has been increased to over 400 providers per reporting unit to ensure statistical significance, and provides a breakdown in population by adult and pediatrics. Survey results will be shared at upcoming stakeholder meetings and posted online.

Capitation Payments for Proposition 56

Ryan Witz, Assistant Deputy Director, Health Care Financing, and Jennifer Lopez, Chief, Capitated Rates Development Division gave an overview of the Proposition 56 physician supplemental payment programs being implemented for SFY 2017-18 in both the Medi-Cal fee-for-service (FFS) and the Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for the 13 CPT codes will receive the associated supplemental payment increase, in addition to whatever other payment they receive from the state in FFS or from the health plan as a network provider in managed care. The capitation is risk based and does not include non-duals or Part B Medicare recipients as part of the calculations. The 13 CPT codes and supplemental payment information can be found here. Utilization at Federally Qualified Health Centers, Rural Health Centers, Indian Health Clinics, and Cost Based Reimbursement Clinics are excluded from these payment increases. Additionally,

utilization from beneficiaries with Medicare Part B or beneficiaries with both Medicare Part A and B or with Medicare Part A, B and D are also excluded from these payment increases.

The FFS supplemental payment program was approved by Centers for Medicare and Medicaid Services (CMS) and payments were implemented prospectively beginning in early January 2018.

The Managed Care proposal is under CMS review. Subject to CMS approval, plans will be funded through a risk based capitation payment for the Proposition 56 Physician Supplemental Payment increases. Medi-Cal managed care health plans (MCPs) will be required to pay eligible providers based on actual utilization and receipt of the associated encounter.

Sanctions

Nathan Nau, Chief, MCQMD, provided an update on sanctions. DHCS imposed monetary sanctions on three MCPs (California Health and Wellness, Gold Coast, LA Care) for failure to meet its contractual obligations for reporting provider network data through the 274 provider network data file. One MCP, Kaiser had monetary sanctions imposed for its inability to submit all retrospective encounter data by January 1, 2017. California Health and Wellness, Gold Coast and LA Care have worked expeditiously to meet their Corrective Action Plans (CAP) and are compliant now as the 274 data required has been submitted. Kaiser is still under a CAP, but are currently compliant and meeting milestones.

Final Rule

Nathan Nau, Chief, MCQMD, and Aaron Toyama, Chief, Program Monitoring and Compliance Branch, MCQMD, provided an update on Final Rule requirements:

- Annual network certification
    - The APL will be released to MCPs for comment in January 2018.
    - The APL will include certification methodology, submission timelines, state monitoring processes, etc.
    - All templates and exhibits related to annual network certification will be attached to the APL.
- MCP network provider screening and enrollment (APL 17-019)
    - All MCP contracted providers must enroll in the Medi-Cal program.
    - MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements outlined in the APL, or they may direct their network providers to enroll through DHCS. MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.
- Mandatory provider types
    - DHCS started surveying MCPs one year ago to see if they were contracted with an Indian Health Service facility (IHS), Rural Health Center (RHC), Federally Qualified Health Center (FQHC), and Freestanding Birthing Center (FBC).
    - DHCS is continuing to work with MCPs that are unable to meet this requirement.

Evidence of Coverage (EOC)
Stephanie Conde, Chief, Operations Section, Managed Care Operations Division (MCOD), provided an update.

- DHCS sent the EOC to MCPs for feedback in October 2017.
- MCOD will post the finalized EOC on the Health Care Options Customer Service Portal in 2018.

Geographic Managed Care (GMC) Expansion in Sacramento and San Diego Counties
Stephanie Conde, Chief, Operations Section, MCOD, provided an update that Aetna Better Health of California is finalizing readiness activities and will be operational on January 1, 2018.

4. Individual Health Education and Behavioral Assessment

Dr. Elizabeth Albers, Chief, Quality Improvement Section, MCQMD, provided an update on the Staying Healthy Assessment (SHA) which is DHCS' version of the Individual Health Education Behavioral Assessment (IHEBA).

MCPs are required by DHCS contract to ensure that contracted providers use and administer an IHEBA to all Medi-Cal members as part of the Initial Health Assessment (IHA).

The goals of the SHA are to assist MCP providers with the following:

- Identifying and tracking high-risk behaviors of MCP members.
- Prioritizing each member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

The SHA consists of seven age-specific pediatric questionnaires and two adult questionnaires. MCPs may use an alternative IHEBA, a non-SHA IHEBA, with prior approval from MCQMD. DHCS staff codified the SHA advisory committee's research and recommendations into nine draft assessments, which will be included in the APL currently under development. Both the draft APL and nine assessments will be released for MCP and stakeholder review in the near future.

5. Status on APLs and Dual Plan Letters (DPLs)

Dana Durham, Chief, Policy and Medical Monitoring Branch, MCQMD, provided an update on APLs and DPLs issued from June-December 2017.

A list of APLs and DPLs released in the last quarter may be found here.

6. Open Forum

DHCS and Plan Oversight of Delegated Independent Physicians Associations (IPAs) and Medical Groups

- The Department of Managed Health Care (DMHC) and DHCS recently investigated a whistleblower complaint against SynerMed. On November 17, 2017, DHCS issued a Corrective Action Plan (CAP) to seven MCPs in response to this whistleblower complaint alleging widespread deficiencies in SynerMed's utilization management (UM) processes. The seven MCPs delegated UM functions to Medical Groups (MGs) or Independent Provider Asosciations (IPAs), who in turn delegated UM functions to SynerMed. SynerMed is an Administrative Services Organization (ASO). The MCPs were required to submit immediate plan of action to DHCS addressing the status of their impacted membership as well as a corrective action plan for all confirmed deficiencies and timetable for their contracted Medical Groups/IPAs to transition to alternate ASO providers.

- DHCS subsequently became aware of a second whistleblower complaint alleging inappropriate utilization practices including the suppression of referrals to high cost in-network specialty provider Employee Health Systems (EHS), an IPA. EHS contracted with SynerMed to provide ASO services. DHCS, in conjunction with the DMHC, required all MCPs to terminate their contracts with EHS. On December 22, 2017, DHCS issued an amended CAP to the seven affected MCPs outlining additional reporting requirements related to the EHS terminations. DHCS continues to monitor the situation closely. The seven affected MCPs submit weekly status reports on the transition of their Medi-Cal members to alternate MGs/IPAs as well on the ongoing adequacy of their provider networks.

- MCQMD, DHCS Audits and Investigations (A&I), and DMHC have standing meetings to monitor compliance issues.

7. Next Meeting

The next MCAG is scheduled for Thursday, March 8, 2018 at 1700 K Street, Sacramento, CA 95814 from 10:00 a.m. – 1:00 p.m. To request future agenda items or topics for discussion please submit to advisorygroup@dhcs.ca.gov by February 1, 2018.