Medi-Cal Managed Care Advisory Group
Written Responses to Stakeholder Proposed Agenda Items
from December 7, 2017 Meeting

Requested Agenda Items
AB 205 Update

Request:
Please provide an AB 205 update.

Response:
The Department of Health Care Services (DHCS) released the Network Adequacy proposal on July 19, 2017. Assembly Bill (AB) 205 passed into state law on October 13, 2017 with new requirements effective January 1, 2018 and July 1, 2018.

- Time and distance standards effective January 1, 2018: Primary care (adult and pediatric), OB/GYN (serving as a primary care provider), Hospitals, Dental services (adult and pediatric).

- Time and distance standards effective July 1, 2018: Pharmacy, Mental Health non-physician (adult and pediatric), Outpatient Mental Health Services, Outpatient substance use disorder services, Opioid Treatment Programs, Core Specialty care (adult and pediatric). The time and distance standards vary, based upon county size.

- Additional standards effective July 1, 2018: Availability of services, assurances of adequate capacity and services, timely access, timely and adequate notice of adverse benefit determinations and related Medi-Cal managed care health plan (MCP) appeal timeframes.

DHCS monitors to ensure network adequacy through a variety of measures. Plans must demonstrate to the department its compliance with the time and distance. The report shall measure compliance separately for adult and pediatric services for primary care. The data is categorized into areas such as geographic access to providers, out-of-network requests/referrals/denials, provider-to-enrollee ratios, provider capacity, access-related grievances.

DHCS dialogues on an annual and quarterly basis with the Plans to ensure that all identified network concerns are appropriately addressed and corrected. If findings in a particular area continue to occur and remain unresolved, DHCS may impose a Corrective Action Plan or initiate enhanced monitoring.
Plans unable to meet the time and distance standards as required in the bill, may submit a request for alternative access standard to DHCS, in a form and manner specified by DHCS. Requests may be submitted at the same time as the annual demonstration of compliance with time and distance, if known. Alternative access standard reviews are to be reviewed within a 90-day timeframe. The department may

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stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. DHCS will post all approved alternative access standards on its internet web site. DHCS shall specify in this report those Plans, if any, that were subject to a corrective action plan due to noncompliance with the time and distance and appointment time standards implemented pursuant to this section during the applicable year and the basis for the departments finding of noncompliance. The report shall include a Plan's response to the corrective plan, if available.
Medi-Cal Managed Care Ombudsman Phone System **Request:** Please provide an update on the Ombudsman phone system data. **Response:** The July 2017 Ombudsman Report may be found here. The August 2017 Ombudsman Report may be found here. The September 2017 Ombudsman Report may be found here.
Transportation Panel Discussion **Request:** Add Transportation as a panel discussion for an upcoming meeting. **Response:** The topic of Transportation will be considered for upcoming meetings.
Quality Strategy Report Update **Request:** Were any comments incorporated into Quality of Care Report? Were any changes made based upon public comments? Has the final been submitted to CMS? **Response:** Several comments were received on the Quality Strategy Report and incorporated into the final draft found here. It was submitted to Center for Medicare and Medicaid Services (CMS) on October 30, 2017. Once DHCS receives feedback and final approval from CMS, the report will be posted online. Many of the comments which

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were not specifically directed towards issues in the Quality Strategy Report were also taken as feedback for consideration and possible future initiatives.
Update on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Plan Compliance **Request:** Update on plan compliance with mental health parity EPSDT (note, EPSDT already assumes mental health parity on paper it is a question of whether that is the reality and that is what we want to know if they are monitoring for children) **Response:** The CMS Parity Compliance Toolkit provides that an Alternative Benefit Plan (ABP) that provides EPSDT benefits is deemed compliant with parity requirements for beneficiaries entitled to EPSDT benefits. DHCS monitors access issues quarterly for all age groups. If there is a significant access issue for children, DHCS would investigate what constituted the access issue and in what benefit the issue existed. Additionally, DHCS further clarified how the EPSDT benefit is to be delivered in APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services found here.
Coordination Between Genetically Handicapped Person Program (GHPP) and Managed Care **Request:** How do the managed care plans work with the Genetically Handicapped Person Program? In support of SB 643, making Duchenne's Muscular Dystrophy a GHPP condition and thus more seamlessly moving kids from CCS to GHPP (it was not signed by Governor), I recently learned that a Best Practices in Managed Medi-Cal Coordination Conference was held in 2014 with Hemophelia Treatment Centers. I believe Sarah Brooks and Nathan Nau attended. Were there any results that could be reported on or follow up? Could we do another panel on this, if not for December (I've also requested for Comprehensive Perinatal Services) maybe then for March of 2018? In the meantime, perhaps just a report on the coordination between GHPP and managed care? I am concerned that the specialties that many GHPP beneficiaries need don't rise to the level of consideration for specialty care distance and travel standards. **Response:** GHPP will only cover an annual Special Care Center visit and blood factor. For all other services, the member will have to go through their MCP. It is not required that a managed care member disenroll from the MCP to become a Genetically Handicapped Person Program (GHPP) beneficiary. As needed though, coordination of care for

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individuals, needing to be seen at Specialty Care Centers for such cases as Hemophilia, Cystic Fibrosis, Sickle Cell, and other specified genetic diseases is organized between the MCPs and GHPP program. Although there is individual coordination that occurs, currently, there is not an overall report available to share at this time. Additional information regarding GHPP may be found here.
Update on EQRO Focus Study on developmental screenings **Request:** Update on next steps from the DHCS developmental screening focus study and an update on childhood immunization rates and quality improvement initiative **Response:** With regards to developmental screening, DHCS has met with Children Now and the California Department of Public Health (CDPH) Maternal and Child Health program to discuss the study results and possibilities for future collaboration. DHCS has also shared data from the study with CDPH and Children Now in the hopes that their review may help to facilitate local interventions and strategies with other key stakeholders for the purposes of sharing any promising practices. DHCS has also shared individual health plan data as well as aggregate statewide data with each of the MCPs so that the plans can review internally for future discussions on possible interventions with DHCS. Childhood immunization (CIS-3) rates for Reporting Year (RY) 2017 (Measurement Year [MY] 2016) neither improved nor declined as compared to RY 2016 (MY 2015) rates. In an attempt to intensify efforts around improving immunization rates for two year olds, DHCS has required that any MCP with a CIS-3 rate below the minimum performance level (MPL) for RY 2017 must do a performance improvement project (PIP) on CIS-3. Further, any MCP with a CIS-3 rate below the statewide weighted average and a declining trend as compared to RY 2016 must also do a PIP on CIS-3. PIPs are an eighteen month long quality improvement process designed to help MCPs identify barriers and evidence based interventions to then test using rapid cycle small tests of change. As a result of this requirement 11 MCPs are doing PIPs on CIS-3. An additional 3 MCPs have also chosen to do a PIP on CIS-3. DHCS will also continue its joint DHCS, external quality review organization, and MCP quality improvement collaborative on immunizations throughout 2018 and 2019.
Quality of Care Initiatives **Request:** Are there any quality of care initiatives in maternity that address prematurity? March of Dimes, ACOG and others have highlighted the use of 17P – progesterone

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injections reducing women's risk of recurrent preterm birth by 33% - only 7-47% of women at risk get this. **Response:** In 2015, DHCS published All Plan Letter (APL) 15-009 "Proper Use and Billing for Makena" to supersede the prior APL on the topic (13-016). APL 15-009 describes the requirements for MCPs coverage of Makena to treat women at risk of recurrent preterm birth. To ensure members are able to access medically necessary treatments in a timely manner, DHCS has continued to discuss requirements related to Makena with MCPs to ensure all MCPs remain aware of the policy and all MCPs ensure their delegated entities are aware of the policy. In addition, the Office of the Medical Director is on the Prematurity Leadership Council. This is a group that is sponsored by the March of Dimes and includes California Department of Public Health, University of California San Francisco, Maternal Child and Adolescent Health, and others. Work on this group has included attending a Summit in Los Angeles (LA) and working on lowering prematurity rates in the African American population, with a specific focus on LA.