Medi-Cal Managed Care Advisory Group
Written Responses to Stakeholder Proposed Agenda Items
for September 13, 2018 Meeting

Written Response
Quality Strategy and Disparities Report **Kiran Savage-Sangwan, CPEHN** We'd like to have a discussion about the Quality Strategy and Disparities Report and have specific questions as outlined below: • What efforts are being made to integrate data from all four managed care programs? • What can be done to improve demographic data collection, including an update on how DHCS is implementing voluntary collection of SOGI data? • What can be done to gather more relevant data regarding consumer experience, including translation and annual administration of CAHPS? • How does DHCS set the MPL? Why? Will you consider raising it? • Please review the quality improvement projects and progress. Can there be efforts to expand and standardize the health disparities projects? • Will DHCS consider instituting a financial incentives program pursuant to what is allowable under federal regulations? • EQRO – when will there be an analysis of the quality metrics by demographics? **DHCS Response:** DHCS is currently working with the Centers for Medicare and Medicaid Services (CMS) on the Quality Strategy and Disparities Report. DHCS will present on the report at an upcoming meeting when the results are available.
Mental Health Services **Lynn Thull, CACFS** How many individuals under the age of 21 are receiving mental health services from Medi-Cal managed care organizations, and what are the services they are receiving (plus any other details you have about their care such as county specific data, frequency, penetration rates, etc.). **DHCS Response:** The Statewide Aggregate Specialty Mental Health Services Performance Dashboard may be found here. At this time, non-specialty mental health services utilization is not currently

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captured; however the Managed Care Performance Dashboard found here provides data on referrals, grievances and appeals, and continuity of care requests.
Prop 56 Update **Mike Odeh, Children Now** Please provide an update on the status of the Proposition 56 rate increases for well-child visits approved in the 2018-19 budget. How does DHCS intend to educate and promote the rate increases to providers and health plans? How is DHCS planning to measure or evaluate the impact of the well-child rate increases? **DHCS Response:** 1. State Plan Amendment 18-0033, proposing to extend the Proposition 56 increases for certain physician services for 2018-19, has been approved by the federal Centers for Medicare & Medicaid Services (CMS). Additionally, DHCS submitted a proposal to CMS in June 2018 to implement the 2018-19 Proposition 56 increases in the managed care delivery system. In anticipation of this proposal being approved, DHCS is finalizing the 2018-19 Medi-Cal managed care rates reflective of the Proposition 56 increases (est. submission to CMS in early 2019). 2. The 2018-19 Proposition 56 increases continue and build on the preexisting increases implemented in 2017-18. MCPs and providers are well aware of the increases and DHCS continues to provide guidance and education through its public website (http://www.dhcs.ca.gov/services/Pages/DP-Physicians.aspx) and communications in existing stakeholder forums and with industry associations such as the California Medical Association. In addition, DHCS issues formal guidance to MCPs via All-Plan Letters. APL 18-010 was issued for the 2017-18 Proposition 56 increases, and an APL specific to the 2018-19 increases will be issued after CMS approves the managed care proposal submitted in June 2018. 3. DHCS' proposal to CMS to implement the Proposition 56 increases in managed care includes a required evaluation component (see the approved 2017-18 proposal for further details). At this time, DHCS continues to assess the best approach for proceeding with the evaluation.
Prop 56 **Adam Francis, CA Academy of Family Physicians** My proposed agenda item would be an overview of the roll out of the Prop 56 Medi-Cal payment money to providers in Managed Care settings. Would be nice to hear from both DHCS and plans as to how this will be operationalized.

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DHCS Response: Proposition 56 payments in 2017-18 were implemented pursuant to the process described in APL 18-010, and the 2018-19 payments will be implemented in a similar fashion. Per the APL, MCPs are required to have a process to communicate with providers about the Proposition 56 payment process, including how payments will be processed, how to file a provider grievance, and how to determine who the payer will be.
Prop 56 **Myriam Valdez, Health Access California** Proposition 56 Medi-Cal funding – summary of new investments, status of federal approval, data on effect provider rate increases are having on access. **DHCS Response:** State Plan Amendment 18-0033, proposing to extend the Proposition 56 increases for certain physician services for 2018-19, has been approved by the federal Centers for Medicare & Medicaid Services (CMS). Additionally, DHCS submitted a proposal to CMS in June 2018 to implement the 2018-19 Proposition 56 increases in the managed care delivery system. In anticipation of this proposal being approved, DHCS is finalizing the 2018-19 Medi-Cal managed care rates reflective of the Proposition 56 increases (est. submission to CMS in early 2019). DHCS' proposal to CMS to implement the Proposition 56 increases in managed care includes a required evaluation component (see the approved 2017-18 proposal for further details). At this time, DHCS continues to assess the best approach for proceeding with the evaluation.
Monitoring and Compliance **Mike Odeh, Children Now** Please describe how DHCS is monitoring health plan compliance with EPSDT and Bright Futures periodicity in particular. Can DHCS identify how the statutory, regulatory, contractual requirements, and guidance documents are clearly aligned to address confusion amongst stakeholders? **DHCS Response:** MCPs are required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of 21, including EPSDT Supplemental Services.

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DHCS continuously monitors MCP compliance with DHCS contractual requirements and state and federal laws, including those mandating EPSDT. On March 2, 2018, DHCS issued All Plan Letter (APL) 18-007 to all MCPs to reinforce the existing state and federal laws and regulations regarding the provision of EPSDT services. Per APL 18-007, the EPSDT benefit in California is set forth under Title 22, CCR, Sections 51340, 51340.1, and 51184. It includes all medically necessary services as described under Title 22, CCR, Section 51184, and Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services" in the MCP contract with DHCS. MCPs are also responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws, contractual requirements, and DHCS All Plan Letters. In addition, DHCS Audits and Investigations Division (A&I) conducts annual audits of all MCPs. During the audit, A&I reviews and verifies MCP compliance with state and federal law, DHCS contractual requirements, and DHCS All Plan Letters. Audit category 2 (Case Management and Coordination of Care) contains the evaluation tools specific to the provision of EPSDT services, including those relating to the provision of medically necessary BHT services to members under 21 years of age as required by the EPSDT mandate.
Social Determinants of Health **Mike Odeh, Children Now** How is DHCS engaging with health plans and/or other state Departments or agencies in order to identify and address the social determinants of health (SDOH) for children? **DHCS Response:** Due to the complexity of the topic, DHCS will present on Social Determinants of Health at an upcoming MCAG meeting.
Health Education **Mike Odeh, Children Now** Can DHCS please provide clarity or point stakeholders to the relevant guidance (APL, provider manual, etc.) around what is currently allowable with respect to Medi-Cal providers delivering health education or other preventive services by non-licensed professionals (such as community health workers) in the clinic setting? How does this authority apply to community, home, or school settings?

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DHCS Response: DHCS Health Educators will be invited to present at an upcoming MCAG meeting and the requested topic will be addressed.
HEDIS results **Sarah Royce, CDPH** Update on the dashboard—when will HEDIS results for MY 2017 be displayed? **DHCS Response:** DHCS reported on the MY2017 Aggregated Quality Factor Scores in the September release of the Managed Care Performance Monitoring Dashboard Report, which can be found here.
Transgender services barriers **Linda Nguy, Western Center on Law & Poverty** Advocates report delays and barriers accessing transgender services due to insufficient providers and lack of training on cultural competency serving transgender population. Below are three cases from Orange County: 1. Arta plan under CalOptima had no competent provider in-network so the plan contracted with out of network provider for facial feminization surgery, but for some reason, most likely due to the pay rate, the Letter of Agreement did not go through. So the plan looked for another out of network provider. The process started all over again with the new provider. The new provider had to submit a new authorization and the plan needed to work out a new LOA which caused a long delay for the patient. 2. Female to Male (FTM) with Medi-Cal through CalOptima under Regal network. Regal denied the client's request for top. Client appealed on his own and CalOptima overturned the denial because Regal failed to follow WPATH's standard of care. Regal told him verbally that they could refer him to an in-network general surgeon for top surgery because they did not have anyone in-network who could do that specific surgery. Client did not think a general surgeon was capable of performing top surgery & CalOptima agreed with him. Ultimately, client switched networks to Monarch and had top surgery 2 months later by an experienced San Francisco surgeon. CalOptima coordinated with the surgeon's office and everything was paid for. Case closed.

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3. FTM with Medi-Cal through CalOptima under Arta network. Client's top surgery was approved. However, Arta referred him to a hand surgeon with little experience in male chest reconstruction. Client did internet research and found another transgender person who had top surgery by the hand surgeon with terrible results. CalOptima was unable to answer his questions about the hand surgeon and recommended that he file an appeal. Client switched over to the Monarch network for referral to an experienced top surgeon because he heard that Monarch is LGBTQ friendly. However, Monarch referred him to a surgeon who has never performed top surgery. Client requested an experienced, out-of-network top surgeon, but CalOptima denied his request because the client had not provided proof of HRT treatment or psych treatment (of which he's gone through both). We have requested State Hearing. **DHCS Response:** As outlined in APL 16-013, treatment for gender dysphoria is a covered Medi-Cal benefit when medical necessity has been demonstrated or meets the definition of reconstructive surgery. MCPs are required to provide medically necessary services through an out-of-network provider when the MCP is unable to provide services within its network. If an out-of-network provider and CalOptima are unable to execute a contract or Letter of Agreement (LOA), CalOptima must restart the process with a different out-of-network in order to comply with their policies and procedures. Further, MCPs may establish their utilization management (UM) policies within contractual requirements. Because of this, the timeframe and process to receive out-of-network care may vary by MCP. DHCS has reviewed CalOptima's policies and procedures and determined that the clinical standards used to make medical necessity determinations are in accordance with the most current "Standards of Care for the Health Transsexual, Transgender, and Gender Nonconforming People." If a beneficiary disagrees with an MCP's decision regarding care, the beneficiary may appeal the decision with the MCP. If a beneficiary does not agree with the decision of the appeal, they may request a state hearing or independent medical review. DHCS will not comment on ongoing state hearings. More information on APL 16-013 may be found here.
Health Homes Program **Linda Nguy, Western Center on Law and Poverty**

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To measure some effectiveness of outreach strategies, can you share how many potential beneficiaries there are? **DHCS Response:** On July 1, 2018, Anthem Blue Cross and San Francisco Health Plan officially began their Health Homes Program implementations in San Francisco County. HHP is designed for the highest-risk 3-5% of the Medi-Cal population. Given the challenges with engaging members in this HHP target population and the intention to reach those members that have the highest opportunity for improved health outcomes, DHCS expects a gradual increase in enrollment as members are outreached and engaged.