Medi-Cal Managed Care Advisory Group
Written Responses to Stakeholder Proposed Agenda Items
from March 8, 2018 Meeting

Written Responses

Data on Children's Mental Health Services Usage

Request:
Still requesting detailed information about children's use of mental health services. For example, number of youth, type of service, duration, intensity, etc.

Response:
Although the Department of Health Care Services (DHCS) continues to monitor this population closely, DHCS does not have data readily available for public reporting at this time.

APL17-019 - PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

Request:
We have had several questions pertaining to APL 17-019 by the Medi-Cal Managed Care Plans (MCPs) and Federally Qualified Health Center (FQHC) providers.

Many FQHCs enroll as an entity to participate in the Medi-Cal FFS Program; however, the individual providers in the FQHC may not all be enrolled. We are seeking clarification from DHCS as to whether this is permissible.

If adding this as an agenda item is not feasible, I would greatly appreciate any information that could be provided to share with our MCPs and FQHCs.

Response:
In order to provide services to FQHC members at the FQHC site, providers must enroll in Medi-Cal as Ordering/Referring/Prescribing providers. In order to provide services to a member outside of the FQHC site, FQHC providers must enroll as an individual Medi-Cal provider. In addition to APL 17-019, further information may be found in the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions found here.

SynerMed/EHS Update

Request #1:
Update on SynerMed/EHS transition activities. If possible, we would like to see examples of the written notices people are receiving about MCPs review of past denials, and the scripts that MCPs are using for phone calls.

Response:
The Managed Care Operations Division (MCOD) followed up with the MCPs after the termination date of 1/31/18 to get an update. No issues or concerns were reported.

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As part of the Corrective Action Plans (CAPs), the Managed Care Quality and Monitoring Division (MCQMD) did not require MCPs to submit call scripts or written notices informing members of deficient SynerMed/EHS practices and the potential impact on authorization requests. MCQMD is monitoring completion of the outbound call campaign through weekly updates submitted by the individual MCPs to ensure that MCPs have reached out to impacted members via telephone and written notice. **Request #2:** Update on status of MCPs compliance with CAPs. **Response:** MCPs were required to submit an overlap analysis to identify the number of providers being removed from the MCP's provider network as a result of the EHS termination. Analysis determined all MCPs remained in compliance with applicable provider-to-enrollee ratios, despite the provider loss. DHCS continues to monitor Continuity of Care through weekly updates provided by the MCPs. All MCPs continue to submit weekly updates and have thus far complied with the reporting requirements delineated in the CAP. Optum, an independent health systems management organization that MCPs have contracted with, additionally supplies DHCS with weekly updates on coordinated efforts. Optum remains onsite at SynerMed headquarters Monday through Friday.
Current Procedural Terminology (CPT) Codes for Cardiac Rehabilitation **Request:** We have recently seen a case where an MCP denied Cardiac Rehabilitation based on the CPT code used to bill for it. Other MCPs will allow providers to bill for that particular CPT code. Since the service is a Medi-Cal benefit, please explain what discretion MCPs have to require providers to use particular CPT codes, and what obligations the MCPs have to inform providers as to which CPT codes are allowable. **Response:** Cardiovascular rehabilitation/intensive cardiovascular rehabilitation is reimbursable under Medi-Cal if the beneficiary has experienced one or more of the following: • Acute coronary syndrome within the preceding 12 months; • A coronary artery bypass surgery; • Current stable angina pectoris; • Percutaneous transluminal coronary angioplasty or coronary stenting; • A heart or heart-lung transplant; • Intermittent claudication due to atherosclerotic disease; or • Stable chronic heart failure. "Chronic heart failure" is defined as left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II – IV symptoms despite being on optimal heart failure therapy for at

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least six weeks. “Stable” is defined as no recent (six months or earlier) major cardiovascular hospitalizations or procedures. The Benefits Division has finalized and approved an Operating Instruction Letter/Document Control Number (OIL/DCN) with the cardiac rehabilitation policy. The final policy may be found in the April 2018 Provider Manual release. The Medi-Cal Provider Manual provides both baseline policy for the Medi-Cal program written largely in terms of covered benefits/services as well as billing/reimbursement guidance for our enrolled Medi-Cal fee-for-service (FFS) providers. As a result, from a coverage/benefit perspective, beneficiaries in FFS and managed care delivery systems receive the same core set of benefits and the Medi-Cal Provider Manual, although tailored to a FFS provider audience, provides baseline policy. While MCPs are held to what is in the Provider Manual in terms of covered Medi-Cal program benefits/services, MCPs can use CPT codes that are not in the Provider Manual but those codes will not be used in calculating the capitated rate. So MCPs have the flexibility to use different codes. Local codes will not be accepted. It is risky to use codes other than the national codes in the Provider Manual in that this may impact the overall capitated rate in the future and therefore, MCPs may require providers to use CPT codes that are consistent with the Provider Manual.
CalViva’s/MCP’s Obligation for Duals **Request:** We have recently seen CalViva enrollees assigned to Kaiser sent transition notices and paperwork, even though they are dual eligibles. Can DHCS explain what CalViva's obligation is with respect to duals? **Response:** Effective September 1, 2017, CalViva Health and Kaiser identified approximately 580 CalViva Health members who had CalViva Medi-Cal in addition to other health coverage. Of these 580 members, approximately 400 were Medi-Cal members who had other commercial (private insurance) health coverage as their primary coverage and Medi-Cal as their secondary coverage. An additional 180 members were identified as “Duals” having Medicare, as their primary insurance and CalViva Medi-Cal as their secondary insurance. Members who had other health coverage were notified prior to the CalViva/Kaiser termination that, since Medi-Cal is always to be the payor of last resort and only covers what is not covered by one’s primary insurance, their coverage would not change.

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Prop. 56 Physician Payments for Managed Care **Request:** Please provide an update on implementation, including the status of physician payments for managed care (rate development). **Response:** Proposition 56 Physician supplemental payment programs have been implemented for SFY 2017-18 in both the Medi-Cal Fee-For-Service (FFS) and in 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 other payment(s) they receive from the State in FFS or from the MCP as a network provider in managed care. The 13 CPT codes and supplemental payment information can be found on the DHCS website at http://www.dhcs.ca.gov/services/medi-cal/Documents/Prop_56_Methodologies_July_31_Notice.pdf. Utilization at Federally Qualified Health Centers, Rural Health Centers, Indian Health Clinics, and Cost Based Reimbursement Clinics is excluded from these payment increases. Additionally, utilization from members with Medicare Part B, with Medicare Part A and B, or with Medicare Part A, B and D, is also excluded from these payment increases. The FFS supplemental payment program was approved by Centers for Medicare and Medicaid Services (CMS) and the supplemental payment increase associated with the 13 CPT codes began in early January 2018. The Managed Care proposal to provide enhanced funding to MCPs through a risk-based capitation payment for the Proposition 56 supplemental payment increases was recently approved by CMS. MCPs are required to pay eligible providers based on actual utilization and receipt of the associated encounter. Payments to MCPs began flowing in April 2018, retroactive back to July 1, 2017, service periods.
Ombudsman Staffing/ SB 97/AB 115 **Myriam Valdez – Health Access** **Request:** Please present 1st quarter report. **Response:** Senate Bill (SB) 97, which was Chaptered on July 10, 2017, requires quarterly reporting of all beneficiary calls received by the DHCS Medi-Cal Managed Care Office of the Ombudsman (OMB). These reports include the number of contacts received by phone and email, the average talk and wait time for beneficiary calls, the number and rate of calls abandoned, the results of the contacts including the destination of the referred calls, and the number of calls referred to another entity. Last year, in

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response to SB 97, MCOD created a webpage on the DHCS website which allows the public to view the quarterly OMB reports. The reports are posted within 45 days of the end of each quarter. The webpage and reports to date can be found on the following link: http://www.dhcs.ca.gov/services/Pages/SB97.aspx. The October 2017 Ombudsman Report may be found here. The November 2017 Ombudsman Report may be found here. The December 2017 Ombudsman Report may be found here.
B-1 Code **Request:** Progress in the area of B-1 code and assignment of newborns to mom's MCP - what data is being kept? Does each MCP have a workaround plan and how does DHCS know if the MCPs' workarounds are successful? **Response:** DHCS is researching the availability of applicable B-1 data and results will be shared at a future date. DHCS monitors MCPs' policies and procedures to ensure that services exist for the Continuity of Care of newborns being assigned into Medi-Cal managed care under their mother's MCP. DHCS is unaware of any MCP "workarounds". MCPs are required to follow all federal, state and contractual requirements, as well as any guidance provided by DHCS.
Status of SB 75 Children **Request:** How are newly integrated children under SB 75 faring? 120 day visits? Vaccinations? **Response:** Currently, DHCS does not require data reporting specific to SB 75. MCPs are contractually required to cover a wide range of preventive services and screenings in accordance with United States Preventive Services Task Force (USPSTF) grade "A" or "B" recommendations, as well as American Academy of Pediatrics/Bright Futures for members under the age of 21 including the SB 75 population. Reports must be made following a member's Initial Health Assessment (IHA) and after all other health care visits that result in an immunization, in accordance with state and federal laws. MCP are contractually required to periodically report member-specific immunization information to an immunization registry(ies) established in the MCPs' service areas as part of the Statewide Immunization Information System. DHCS strongly recommends that not only pharmacists, but all MCP network providers report immunization information within 14 days of administering an immunization. MCPs must also require their network providers to document each member's need for

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Advisory Committee on Immunization Practices (ACIPs)-recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Assessments (IHAs)
- Pharmacy services
- Prenatal and postpartum care
- Pre-travel visits
- Sports, school, or work physicals
- Visits to a local health department
- Well patient checkups

During the medical record review portion of Facility Site Reviews (FSR), nurses review medical records for evidence that the IHA and SHA/IHEBA are completed according to guidelines. FSRs are conducted by the MCP and by DHCS.

Information regarding immunization requirements may be found in APL 18-004.

Cap and Deduct Instances

Request:
Does DHCS keep track of MCPs' episodes of "deduct" instances with providers and Independent Physician Associations (IPAs) when MCPs have to step in and make them provide care? When we have complained about an IPA's lack of service or unwillingness to provide something, at least one MCP has told us they can authorize the service and deduct it from the IPA's capitation. The MCPs used the term(s) "cap and deduct". More generically, does DHCS keep track of when MCPs do not provide the full capitation to IPAs because they had to override IPA denials?

Response:
MCPs are contractually obligated to maintain procedures for monitoring the coordination of care provided to members. This includes, but is not limited to, all medically necessary services delivered both within and outside the MCP's provider network. MCPs must also ensure that medical decisions, including those made by subcontractors and rendering delegated entities, are not unduly influenced by fiscal and/or administrative management. Additionally, they must employ a full-time financial officer to maintain financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles. Records and books of account must fully disclose the disposition of all Medi-Cal program funds received, as specified by their contractual obligations. However, DHCS does not monitor when the MCPs do not provide the full capitation to IPAs because of IPA denial overrides. Unless there is a continual disregard to their obligations, the MCP manages their subcontractor and provider relations.

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Health Disparities Report

Request:
Please provide an update on the status of DHCS' health disparities report (i.e. release date and/or findings, list of metrics and timeline for future reports).

- How will you use this report to hold MCPs accountable for meeting targeted year-over-year improvements in disparities reduction?
- How are you working with plans MCPs to identify appropriate interventions to reach quality and disparities reduction goals?

Response:
The 2015-2016 Managed Care Disparity Study is a disparity analysis based on 2015 EAS (External Accountability Set) measure results for the Medi-Cal Managed Care population. DHCS intends to share pertinent results from the study with the Managed Care Advisory Group (MCAG) in the near future. We are moving forward with plans to continue the Managed Care Disparity Study on an annual basis. DHCS will continue to make improvements to the Managed Care Disparity Study based on lessons learned so that the data can be more actionable for purposes of trending disparities.

One of the required Performance Improvement Projects (PIPs) for MCPs for 2017-2019 is to focus on a statistically significant disparity for a targeted population within the MCP. MCPs have already chosen their disparity PIP topics, the vast majority of which are related to a metric on the External Accountability Set (EAS), and will embark on implementing PIPs to attempt to reduce the identified disparity. In addition, one of the Quality Improvement Learning Collaborative calls for the MCPs for 2018 is focused on health disparities and assisting the MCPs in their health disparity PIP work. The first Collaborative call was successful and highlighted the extensive work of one of the MCPs in reducing health disparities.

Quality Rating System

Request:
Please provide an update regarding the current status of California's Medicaid managed care (MCMC) Quality Rating System (QRS).

- What is DHCS' vision for the QRS?
- How are you engaging consumers, MCPs and other stakeholders in the development of the QRS?
- What, if any, additional federal guidance have you received?

Response:
According to the CMS Medicaid Final Rule, CMS will develop a QRS. States will either adopt the CMS QRS or develop an alternative MCP QRS with approval from CMS. DHCS is developing a comprehensive MCP quality monitoring system, which will run routinely.

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DHCS is awaiting CMS' QRS and will decide to either adopt the CMS QRS or develop an alternative one. If DHCS decides to adopt an alternative QRS, the Final Rule requires that DHCS obtain input from the DHCS Stakeholder Advisory Committee (SAC) and provide an opportunity for public comment of at least 30 days before submitting the QRS for CMS approval. Along with the QRS, DHCS is waiting for any related guidelines.