Medi-Cal Managed Care Advisory Group
Written Responses to Stakeholder Proposed Agenda Items
for June 14, 2018 Meeting

Written Response
Transportation **Request:** There have been quality issues (late and no-shows) with ride-sharing services in providing transportation and ride-sharing services being inappropriately used to provide Non-Emergency Medical Transportation (NEMT). • Where should transportation cases be elevated if Members can't resolve with Medi-Cal managed care plans (MCPs) and can Department of Health Care Services (DHCS) clarify to MCPs that Members requiring door-to-door service, such a dialysis patients, receive NEMT, and that ride-sharing services are not appropriate NEMT providers? • Will there be alignment for MCPs to provide NEMT to health plan benefits and carved out benefits as they are required for Non-Medical Transportation (NMT)? **Response:** Per All Plan Letter (APL) 17-010, Members requiring door-to-door assistance are authorized to receive NEMT if prescribed by a physician or podiatrist. Ride-sharing services, such as Lyft and Uber, are considered NMT providers. APL 17-010 defines MCP requirements for both NEMT and NMT services, as well as when each service must be provided. At this time, DHCS does not require the MCP to cover NEMT for carved-out services and will not be updating the transportation policy to expand this benefit. If a Member cannot resolve a transportation-related issue with their MCP, they should file an appeal with the MCP. A Member can contact DHCS if a resolution is not reached through the MCP's grievance process. Additional information can be found in the FAQ: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010FAQ.pdf.
Dental – AB 2207 **Request:** Pursuant to Assembly Bill (AB) 2207, MCPs are required to coordinate Denti-Cal benefits for Members by including a dental screening in the health risk assessment (HRA), referring Members to the appropriate dental provider, and employing a health plan liaison to work with dental providers to ensure referrals to the MCP for plan-covered services. How are MCPs showing compliance and what enforcement mechanism is DHCS employing? **Response:** MCPs are contractually required to cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. For Members under

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21 years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals at age three (3), or earlier if medically necessary. MCPs must also ensure that Members are referred to appropriate Medi-Cal dental providers. Further, the Child Health and Disability Program (CHDP) will be working with MCPs to follow-up on children that have received a dental referral from an MCP or provider. CHDP will target children from birth to age six, and children/youth under 21 with an urgent or emergent dental problem. CHDP will also provide appointment assistance if it determines that the child did not keep the dental appointment, as referred by the MCP. MCP compliance with care coordination, including dental care coordination, is reviewed as a part of annual medical compliance audits. Additionally, DHCS is currently surveying MCPs on the specific aspects of dental screenings. Once we have that information, DHCS will takes steps to ensure compliance.
Timely Access and Network Certification **Request:** Provide a timely access update and include the timely access compliance methodology and a detailed reporting of timely access survey results beyond the dashboard, for children and adults. **Response:** A Timely Access update will be provided at a later Advisory Group meeting which will include the compliance methodology. The Timely Access survey results are not ready to be shared at this time, but DHCS will present the results in this forum once available.
Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) **Request:** How is DHCS promoting the early periodic screening portion of its EPSDT requirement aside from just clarifying that such services are to be covered by MCPs, but to ensure utilization not just access? This seems to require work with providers via MCPs in education and training/guidance on how to use the appropriate codes. MCPs tell us that they can only do so much to require provider to use, say, developmental screening codes. **Response:** DHCS released APL 18-007: Requirements for Coverage of EPSDT for Medi-Cal Members Under the Age of 21. The APL is intended to reinforce existing state and federal laws and regulations surrounding the provision of EPSDT services, though it

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does not represent a change in policy. Contractually, MCPs must ensure that providers receive training regarding the programs. They must also develop and implement a process to provide information to providers and to train them on a continuing basis. This process shall include an educational program regarding health needs that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of education outreach In addition, DHCS regularly publishes provider bulletins to communicate screening requirements and any changes in policy. DHCS is also in the process of updating the Preventive Services section of the Medi-Cal Provider Manual to list Healthcare Common Procedure Coding System (HCPCS) codes that providers may use to bill for U.S. Preventive Services Task Force Grade A or B recommendations, which include screening services for children. MCPs also incentivize providers to use the appropriate codes. DHCS conducts annual medical audits where the EPSDT benefits are reviewed to ensure compliance. Regarding developmental screening specifically, DHCS shared the results of its focused study on developmental screening with all MCPs so that they are aware of their screening rates. DHCS is aware of at least one MCP that has developed a specific provider incentive for developmental screening and use of the appropriate Current Procedural Terminology (CPT) code as a result. DHCS is also working with external partners including Children Now and the California Department of Public Health on sharing resources and promising practices. Finally, DHCS will be embarking on a project to update its facility site review/medical record review (FSR/MRR) tool in the near future. The MRR is performed during DHCS- and MCP-facilitated FSRs of primary care provider sites to ensure that appropriate preventive services are being provided, as required. While the MRR tool currently checks for the occurrence of developmental screenings, it does not check for the use of a standardized tool. DHCS is currently working to update the MRR tool to include this requirement and will closely review the section that includes developmental screening.
Prop. 56 - Physician Payments for Managed Care **Request:** Update on Prop. 56 the Directed Physician Payment. **Response:** Proposition 56 physician supplemental payment programs have been implemented for FY 2017-18 in both the Medi-Cal Fee-for-Service (FFS) and the Medi-Cal Managed Care delivery systems. Providers that are eligible to bill for the 13 CPT codes will

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receive the associated supplemental payment increase, in addition to the FFS payment they receive from the State or payment they receive from the MCP as a network provider in managed care. Payments to MCPs began flowing in April 2018, retroactive back to July 1, 2017, service periods. The 13 CPT codes and supplemental payment information can be found on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/Prop56.aspx. 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 Members with Medicare Part B, 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 Directed Payment proposal was approved by CMS on February 21, 2018. The approved directed payment proposal provides DHCS with the authority to implement the Proposition 56 Physician Supplemental Payment Program in the managed care delivery system. On May 1, 2018, DHCS released APL 18-010 which requires MCPs to pay eligible providers based on actual utilization and receipt of the associated clean claim or accepted encounter. In addition, DHCS has submitted to CMS for approval, a proposed State Plan Amendment (SPA) to extend the supplemental payment for certain physician services for one year. The effective dates if approved would be July 1, 2018 through June 30, 2019. SPA 18-0033 may be found here.
Prop. 56 - Dental Supplemental Payments **Request:** Please provide an update on utilization and progress for dental supplemental payments. **Response:** Prop. 56 supplemental provider payments began being distributed in December 2017 to FFS providers and in May 2018 to Dental Managed Care (DMC) providers. As of May 14, 2018, $193 million has been paid for Prop. 56 dental services rendered during Fiscal Year (FY) 2017-18. This amount is inclusive of dollars paid to the DMC providers for services rendered July 1, 2017–April 2018 and to FFS providers for services rendered July 1, 2017–March 2018.

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In a comparison of FY 16/17 to FY 17/18, our preliminary results as of April 30, 2018, show for both children and adults, the largest increase in utilization was in visits and diagnostic services. The tables on the following page represent the percentage increases for each category.

Children:

	Total Srvs 16/17	Total Srvs 17/18	Total Increased	% Increase
Visits and Diagnostics	2,844,552	3,313,765	469,213	16.50%
Restorative	2,995,040	3,274,473	279,433	9.33%
Endodontic	459,756	501,543	41,787	9.09%
Prosthetic	447	438	-9	-2.03%
Oral and Maxillofacial	743,910	845,043	101,133	13.59%
Adjunctive	738,803	846,517	107,714	14.58%

Adults:

	Total Srvs 16/17	Total Srvs 17/18	Total Increased	% Increase
Visits and Diagnostics	836,595	1,156,529	319,934	38.24%
Restorative	1,090,394	1,256,059	165,665	15.19%
Endodontic	28,370	48,361	19,991	70.46%
Prosthetic	201,415	209,909	8,494	4.22%
Oral and Maxillofacial	890,249	910,593	20,344	2.29%
Adjunctive	486,056	599,958	113,902	23.43%

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In addition, DHCS has developed a proposal for dental supplemental payments for FY 2018-19. This proposal was informed in part by the dental procedure codes subject to supplemental payments in FY 2017-18 and stakeholder feedback received for proposed changes. The Prop. 56 proposal for FY 2018-19: • Continues the supplemental payments from FY 2017-18 at 40 percent of the Schedule of Maximum Allowance (SMA); • Identifies among the 26 most utilized dental services, and additional services; such as adult preventive services, not previously covered, that will be subject to supplemental payments in FY 2018-19 (Attachment A); • Adds periodontal services to receive a supplemental payment of 40 percent of SMA for periodontal services; • Allows for extended appointment time for special needs Members; • Creates general anesthesia parity for dental services with that of medical anesthesia; and • Adds a supplemental payment for orthodontic appliance removal. DHCS maintains a goal towards choosing supplemental payments that will yield increased provider participation and Member utilization of services. **Dental Provider Loan Repayment**: The Administration proposes to utilize approximately $30 million from the 2017-18 amount dedicated for dental supplemental payments using Prop 56 funding to redirect to the Office of Statewide Health Planning and Development (OSHPD) to administer a loan repayment program for dentists. The Department of Health Care Services (DHCS) will work with OSHPD to develop the criteria for this loan repayment program, and anticipates the criteria will include several provisions to direct these funds to dentists providing care in underserved areas and/or in areas where there are high concentrations of Medi-Cal populations. This proposal may also help financially support dentists that want to relocate their practice to a county or region that currently lacks a dental provider. The Administration also proposes to allocate approximately $210 million in Prop 56 funds in 2018-19 for dental supplemental payments as noted below. **Maintain the 2017/18 supplemental payments for Select Dental Services at 40 Percent of the Schedule of Maximum Allowances (SMA):** The dental supplemental payment categories identified for 2017/18 included restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, and visits and diagnostic services. These payments will be maintained for 2018/19 at the same 40 percent increase of the SMA.

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Incentivize the Top 26 Utilized CDT Codes Using a Percent Change or Specified Dollar Change: Beginning in 2018-19, the Administration proposes to provide additional supplemental payments for the Top 26 utilized dental services, which were otherwise not part of the 2017/18 proposal. This will include adult dental preventive services and periodontal services, based on stakeholder feedback, and adding some additional diagnostic services (such as x-rays). For the Top 26 utilized services, the supplemental payments will either reflect a specific dollar increase per the identified code or will be a percentage increase above the existing Medi-Cal SMA rate; periodontal services will receive a supplemental payment that is 40 percent of the SMA. **Incentivize General Anesthesia and IV Sedation Codes:** General Anesthesia Code CDT 9220 will receive a supplemental payment of $148.65 on top of the existing $91.35 SMA and CDT 9221 will receive a supplemental payment of $110.99 on top of the existing $14.01 SMA. The Intravenous Sedation Codes (CDT 9241 and 9242) will receive a supplemental payment equal to 40 percent of the current SMA. **Allowances for Additional Time for Individuals with Special Health Care Needs:** Based on stakeholder feedback, CDT 9430 will be used for dental providers to be reimbursed for additional time needed by individuals with special health care needs. The associated supplemental payment will be 60 percent of the SMA. The FY 2018-19 package of supplemental payments proposed would be effective July 1, 2018, contingent on receipt of federal approval. The new payments will be applied in both Medi-Cal dental fee-for-service and dental managed care delivery systems. DHCS also proposes to utilize approximately $30 million from the FY 2017-18 Prop. 56 funds to be redirected to the Office of Statewide Health Planning and Development to administer a loan repayment program for dentists. Contingent on approval by the Legislature, DHCS will post the details for these proposed supplemental payment methodologies and submit all necessary documentation to the federal government no later than September 30, 2018. More information may be found on the Medi-Cal Dental webpage.
Diabetes Prevention Program Update **Request:** Provide a Diabetes Prevention Program Update.

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Response: DHCS is working with Medi-Cal's fiscal intermediary to finalize the Diabetes Prevention Program (DPP) policy, and continues to collaborate with the Centers for Disease Control and Prevention, CMS, and other state Medicaid agencies to learn best practices for the DPP, as well as develop and further refine implementation strategies. Deliverables for MCP readiness are being assessed in areas such as, but not limited to, provider network, Evidence of Coverage, financial review, and quality improvement system areas. DHCS will publish a dedicated section in the Medi-Cal Provider Manual to inform providers as to applicable DPP coverage and reimbursement policy. In addition, the Managed Care Quality and Monitoring Division will provide additional guidance to MCPs in a forthcoming APL.
B-1 **Request:** When will an All Plan or Policy Letter on the B1 process be issued? Will advocates have an opportunity to see it in draft for review and comment before it is finalized? Plans have indicated they cannot assign a primary care physician (PCP) to a newborn until the first of the following month, which also blocks access to specialists. Health Care Options has indicated it cannot change a newborn's Medi-Cal plan until after the month following the birth month at earliest. What changes to the B1 process will the Department adopt to ensure compliance with the timely access to care standards for B1 newborns? Advocates would like to discuss the following proposals with Advisory Committee members: End B1 and return to FFS during the birth month and month after, as required by state law. Until that time, adopt the following interim measures for timely access to care: **1) Notice** Notice to the mother, both during the pregnancy and again when she enrolls the newborn into Medi-Cal in the birth month or month after, that her baby is going to be enrolled into her MCP and that she will need to choose a PCP for her baby, with info about the steps for choosing a PCP and who to contact if the family needs to have the newborn in an MCP different from the mother's plan. This notice must be in addition to generic "welcome to the plan" materials sent when the newborn is auto-enrolled into the mother's plan. **2) Open access in MCP, including to specialists**

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Until a PCP has been selected for the newborn in the mother's plan, newborns must have open access in the plan to all providers, including specialists, during the B1 period. **3) Expedited process for changing a newborn's MCP when necessary during the B1 period** Example of when necessary: newborn is sick and requires continuity of care with hospital pediatrician who attended the birth, but who is not in the mother's plan; the family's pediatrician cares for siblings in an MCP different from the mother's plan; mother and/or siblings in LA Kaiser sub-plan, but newborn auto-enrolled into LA Care plan instead; mother and/or siblings in Kaiser, new Medi-Cal Kaiser enrollments capped, newborn's auto-enrollment goes to another plan. **4) Dedicated unit** At each MCP to assist with B1 newborn issues. Information about this in notice to mother, and to providers, etc. **5) Training for plan providers and Member services representative** **Response:** Policies and procedures are MCP specific and have been confirmed to meet the requirements as delegated by DHCS. Therefore, no changes will be made to the B1 process at this time. Guidance regarding how MCPs should handle newborns before they receive a CIN may be considered in a future APL. Also for consideration, is a letter of confirmation to the newborn's parent or guardian confirming the newborn's enrollment into an MCP, and the option to change to another MCP, if available.
New MCP Handbook **Request:** Please provide an update on implementation of the new managed care handbook **Response:** The Evidence of Coverage (EOC) template was updated to meet the requirements of the Final Rule in 2017. MCPs submitted their updated EOCs to DHCS for review and approval in preparation for their annual mailings in 2018.

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Attachment A

DHCS Top 26 Most Utilized Dental Services + General Anesthesia/IV Sedation

For 2018-19, DHCS has identified additional codes to add to the list of services subject to the Proposition 56 (P56) dental supplemental payment program. The additional CDT codes, in part, are based on stakeholder input and are also among the most utilized dental services under Medi-Cal. Below is a chart, representing the top 26 most utilized dental codes and the corresponding P56 supplemental amounts. The dental codes listed in ***bold italics*** represent those services that were not part of the 2017-18 P56 program.

Category	CDT Code	Existing Medi-Cal Rate 2018	P56 Supp. % or Proposed Rate	Proposed Medi-Cal Rate with Prop 56	Notes
Diagnostic	D0120	$15.00	$30.00	$45.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is replaced with a specific dollar amount
Diagnostic	D0145	$20.00	$39.00	$59.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is replaced with a specific dollar amount
Diagnostic	D0150	$24.00	$41.00	$65.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is replaced with a specific dollar amount
Diagnostic	***D0210***	***$40.00***	***20%***	***$48.00***	***Newly added diagnostic code for 18/19 - P56 supplement is 20% of the SMA***
Diagnostic	***D0220***	***$10.00***	***20%***	***$12.00***	***Newly added diagnostic code for 18/19 - P56 supplement is 20% of the SMA***
Diagnostic	***D0230***	***$3.00***	***35%***	***$4.05***	***Newly added diagnostic code for 18/19 - P56 supplement is 35% of the SMA increase***
Diagnostic	***D0272***	***$10.00***	***20%***	***$12.00***	***Newly added diagnostic code for 18/19 - P56 supplement is 20% of the SMA***
Diagnostic	***D0274***	***$18.00***	***20%***	***$21.60***	***Newly added diagnostic code for 18/19 - P56 supplement is 20% of the SMA***
Diagnostic	***D0330***	***$25.00***	***20%***	***$30.00***	***Newly added diagnostic code for 18/19 - P56 supplement is 20% of the SMA***
Diagnostic	***D0350***	***$6.00***	***60%***	***$9.60***	***Newly added diagnostic code for 18/19 - P56 supplement is 60% of the SMA***
Preventive	***D1110***	***$40.00***	***$50.00***	***$90.00***	***Newly added code for 18/19 based on stakeholder feedback – P56 supplement is a specific dollar amount***
Preventive	***D1206***	***$18.00***	***$12.00***	***$30.00***	***Newly added code for 18/19 based on stakeholder feedback – P56 supplement is a specific dollar amount***
Preventive	***D1208***	***$18.00***	***$9.00***	***$27.00***	***Newly added code for 18/19 based on stakeholder feedback – P56 supplement is a specific dollar amount***
Restorative	D2140	$39.00	40%	$54.60	Was part of 17/18 P56; no change for 18/19 P56 supplement
Restorative	D2150	$48.00	40%	$67.20	Was part of 17/18 P56; no change for 18/19 P56 supplement

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Category	CDT Code	Existing Medi-Cal Rate 2018	P56 Supp. % or Proposed Rate	Proposed Medi-Cal Rate with Prop 56	Notes
Restorative	D2160	$57.00	40%	$79.80	Was part of 17/18 P56; no change for 18/19 P56 supplement
Restorative	D2330	$55.00	40%	$77.00	Was part of 17/18 P56; no change for 18/19 P56 supplement
Restorative	D2391	$39.00	40%	$54.60	Was part of 17/18 P56; no change for 18/19 P56 supplement
Restorative	D2392	$48.00	40%	$67.20	Was part of 17/18 P56; no change for 18/19 P56 supplement
Restorative	D2930	$75.00	60%	$120.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is 60% of the SMA
Endodontics	D3220	$71.00	40%	$99.40	Was part of 17/18 P56; no change for 18/19 P56 supplement
O&M Surgery	D7140	$41.00	40%	$57.40	Was part of 17/18 P56; no change for 18/19 P56 supplement
O&M Surgery	D7210	$85.00	40%	$119.00	Was part of 17/18 P56; no change for 18/19 P56 supplement
Adjunctive (GA)	D9220	$91.35	$148.65	$240.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is replaced with a specific dollar amount
Adjunctive (GA)	D9221	$14.01	$110.99	$125.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is replaced with a specific dollar amount
Adjunctive (IV)	D9241	$42.14	40%	$59.00	Was part of 17/18 P56; no change for 18/19 P56 supplement
Adjunctive (IV)	D9242	$21.07	40%	$29.50	Was part of 17/18 P56; no change for 18/19 P56 supplement
Adjunctive (Anesth.)	D9230	$25.00	60%	$40.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is 60% of the SMA
Adjunctive (Office Obs.)	D9430	$20.00	60%	$32.00	For 17/18, P56 supplement was 40% of the SMA; for 18/19, P56 supplement is 60% of the SMA