Managed Care Final Rule: 2018 Annual Network Certification

California Department of Health Care Services

Stakeholder Advisory Committee Meeting
July 18, 2018

Presentation Outline

1. Overview of Requirements
2. Managed Care Plan (MCP)
3. Drug Medi-Cal Organized Delivery System (DMC-ODS)
4. Specialty Mental Health Services (SMHS)
5. Dental Managed Care
6. Public Reporting
7. Questions and Open Discussion

Overview of Requirements

AB 205

- **Implemented** specific provisions of the Final Rule, including the network adequacy standards
- **Changed** county categorization to be based on population density rather than population size
- **Authorized** alternative access standards (AAS) process to be permitted and use of telehealth to meet standards
- **Established** a 90-day timeline for reviewing alternative access standard requests
- **Requires** annual demonstration of network adequacy compliance
- **Sunsets** the network adequacy provision in 2022, allowing for reevaluation of the standards

Time and Distance

- Primary Care Physicians*
- Core Specialists*
- Outpatient Mental Health*
- OB/GYN (Primary and Specialty Care)
- Hospitals
- Pharmacy

Mandatory Providers Types

- Federally Qualified Health Centers (FQHCs)
- Freestanding Birthing Centers
- Rural Health Clinics (RHCs)
- Indian Health Facilities (IHFs)
- Midwifery Services

Provider to Member Ratios

- Primary Care Physician (PCP) Ratio
- Total Physician Ratio

* Adult and pediatric

Alternative Access

- **AAS requests were approved for time and distance standards if either**:
  - The Plan has exhausted all other reasonable options to obtain providers to meet the time and distance standards; or
  - DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
- **Telehealth** may be used as a means of determining alternative access standards.

Managed Care Plan (MCP Network Certification Approach and Results

Network Certification Components and Guidance

- **Components**
  - Physician and Primary Care Provider Ratios
  - Mandatory Provider Types
  - Primary Care Provider and Specialist Time and Distance Standards
- **Plan Guidance**
  - DHCS released the Network Certification All Plan Letter (APL) in February 2018 and provided Managed Care Plans (MCPs) with technical assistance on data submission requirements.

Approach to Provider Ratios

- Requested MCPs submit aggregate provider counts of the total PCPs and total network physicians, taking Full Time Equivalents (FTE) into account for their reporting units
- Calculated the provider-to-member ratio using the total number of providers contracted with the MCP divided by the projected enrollment for the following contract year
- Contacted a random sample of PCPs and core specialists to validate each MCP's provider network and confirm there are executed contracts

Approach to Mandatory Provider Types

- FQHCs, RHCs, IHFs, freestanding birthing centers, midwifery services
- Assessed the MCPs' submissions and confirmed that all MCPs had entered into a contract or demonstrated good faith contracting efforts
- Validated the submissions by verifying reported differences in the same contracted service area

Approach for Time & Distance Standards

- Requested MCPs submit geographic access maps or accessibility analyses that demonstrated compliance with applicable time or distance standards, or requested Alternative Access Standard (AAS) approval for the entire service area
- Reviewed provider networks to verify time and distance standards, by county population density, were being met for the specific provider types
- Verified the entire service area was covered to meet the standards
- Required AAS requests to be submitted if time and distance standards were not met

AAS Approved

- Over 10,000 AAS requests have been approved and included in the Annual Network Certification.
- Patterns of requests included:
  - Geographically remote regions, primarily for specialists
  - Time and distance standards for specialists – specifically, pediatric specialists – in both rural and urban counties
  - MCPs unable to contract with the nearest provider when serving beneficiaries within the same zip code as another MCP – providers contract with one plan but not the other, resulting in the MCP unable to contract with the nearest provider

2018 Annual Network Certification Results

- 9 Plans did not meet the initial Annual Network Certification requirements:

Anthem	**Care 1st**	**Inland Empire Health Plan**
Aetna	**Central California Alliance for Health**	**LA Care**
California Health and Wellness	**Health Net**	**United**

2018 Annual Network Certification Results

- Plans under a CAP were not meeting time and distance standards for a required provider type(s) and:
  - Submitted alternative access late and is currently being reviewed by DHCS
  - Had alternative access request denied
  - Requested alternative access but was partially approved for less than the requested time and distance standard
  - The requested alternative access does not cover the entire service area
- All Plans met the requirements for provider-to-member ratios and mandatory provider types.

MCP Corrective Action Plan (CAP)

CAP Process

- Plans that did not meet the certification requirements had a Network Adequacy CAP imposed.
- DHCS held CAP entrance conferences to discuss specific deficiencies with each Plan under a CAP.
- Plans will have 6 months to rectify the deficiencies and are required to report on the progress monthly.
  - If the plan is unable to close the CAP within six months, they will be required to report weekly thereafter.
- DHCS will continue to monitor and may impose sanctions and/or penalties if full compliance is not met.

Temporary Standard and Other Requirements

- **Out-of-network access**
  - Plans under a CAP are deemed in compliance with an approved temporary standard that requires authorization for out-of-network services within the timely access standards.
- **Member services training**
  - All Plan member services staff who provide information to members for appointments or process authorization requests (including those of subcontractors) are aware of and trained on processing appointments including out-of-network access.
- **Enhanced monitoring**
  - The External Quality Review Organization (EQRO) will conduct a timely access survey to ensure compliance with timely access to appointment standards.
  - DHCS will review Plan training materials and call-center scripts in addition to completing an out-of-network survey to ensure all requirements are being met.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Network Certification

Drug Medi-Cal Organized Delivery System (DMC-ODS)

- **DMC-ODS Plans in operation prior to July 1, 2017 required certification.**
  - Riverside, Marin, San Mateo, Santa Clara, Contra Costa and San Francisco counties were certified.
  - Time and distance standards included outpatient substance use disorder services and opioid treatment services.
  - Guidance was provided in March 22, 2018 DHCS webinar and in Mental Health and Substance Use Disorders Information Notice 18-011.

Network Certification Components

- Plans were required to submit:
  - Completed Network Adequacy Certification Tool
  - Alternative Access Requests
  - Geographic Access Maps
  - Grievances and appeals related to access
  - Multiple policies and procedures
  - Language line utilization
  - Provider agreements and subcontracts

Network Certification Approach

- Data Validation and Analysis:
  - Utilized various data sources (e.g., claims data, enrollment data, eligibility data, provider files) to validate county data submissions.
  - Analyzed Plans' infrastructure through review of supporting documentation.
  - Validated geographic maps.
  - Reviewed Alternative Access Requests.

DMC-ODS Results

- San Mateo, Riverside and Contra Costa submitted Alternative Access Requests.
- Six plans met the Annual Network Adequacy requirements with a conditional pass due to identified deficiencies.
- CAP notices were sent out on July 2, 2018 for deficiencies noted during supporting documentation analysis.
- Plans have 30 calendar days to submit their CAPs.

Specialty Mental Health Services (SMHS) Network Certification

Specialty Mental Health Network Certification

County Information Notice

- Mental Health and Substance Use Disorder Services Information Notice 18-011

MHP Reporting Requirements

- Network provider data reported for each organization, site and rendering provider
- Geographic Access Maps
- Expected utilization of SMHS
- Alternative Access Standards
- American Indian Health Facilities
- Supporting documentation, including: language line utilization, grievances, and policies & procedures

Annual Network Certification Methodology

- Anticipated Enrollment and Utilization of SMHS
- Characteristics of the SMHS Population
- Accessibility and Location of Network Providers
- Network Composition and Capacity
- Network Infrastructure

Annual Network Certification Methodology

Anticipated Enrollment and Utilization of SMHS

- DHCS estimated the expected utilization in each county for the following outpatient SMHS:
  - Mental Health Services
  - Case Management
  - Crisis Intervention
  - Intensive Care Coordination
  - Intensive Home Based Services
  - Medication Support Services
- DHCS utilized data from various sources:
  - Medi-Cal Eligibility Data System (MEDS)
  - MHP-submitted SMHS utilization estimates (NACT Exhibit C-2)
  - CA Mental Health and Substance Use System Needs Assessment - Prevalence of Serious Emotional Disturbance (SED) in children/youth and Serious Mental Illness (SMI) in adults
  - Performance and Outcomes Systems (POS)

Estimated Need Determination

Estimated Current Need

=

County Medi-Cal Population (MEDS)

X

County (SMI/SED) Prevalence Rate

Estimated FY18/19 Need

=

Current Need

X

Percent Growth (MHP Projections)

Annual Network Certification Methodology

Characteristics of the SMHS Population – Language Assistance

- Demographic and client characteristic data were obtained from MEDS data and SMHS claims data for FY 16/17.
- DHCS required MHPs to report the linguistic capabilities of each rendering provider in prevalent non-English languages and language line utilization in telephonic and face-to-face encounters.
- MHPs submitted subcontracts for interpretation and language line services.
- For each prevalent non-English language, DHCS calculated each MHP's count of FTE providers classified as "certified" level of fluency.

Annual Network Certification Methodology

Accessibility and Location of Network Providers

- MHPs were required to submit the following geographic access maps:
  - An overview map which delineates boundaries and zip codes.
  - An overview map of all beneficiaries receiving services in the county.
  - Two geographic access maps for each service type (i.e., one each for children and adults) within the geographic area.
- DHCS validated MHP maps using ArcGIS software
- For each site, MHPs were also required to report whether the clinic meets federal accessibility requirements under the ADA

Annual Network Certification Methodology

Network Composition and Capacity

- DHCS established statewide provider-to-beneficiary ratios
- Using POS data - mean service quantity (based on minutes) per unique beneficiary by fiscal year - and MHP reported FTE provider counts
- DHCS summed the mean number of minutes for the various outpatient SMHS (overall average) for adults and children/youth.
- DHCS assumed a 60% productivity rate (i.e., the proportion of an FTE spent on direct billable services) to determine the total productive minutes per FY for each FTE SMHS provider.
- To calculate statewide ratios, DHCS divided the total productive minutes per year by the overall average minutes for adults and children/youth.

Annual Network Certification Methodology

Tele-psychiatry Provider Capacity

- For MHPs utilizing tele-psychiatry and/or Locums Tenens contracts to meet the need for psychiatry services, DHCS calculated the estimated FTE value of the contracts.
- DHCS divided the total FY budget amount by the highest hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract.
- DHCS used the number of allotted hours to calculate the estimated FTE value of the contract.

Annual Network Certification Methodology

Mandatory Provider Types

- The final rule requires Plans to demonstrate to DHCS that the Plan has sufficient Indian Health Care Providers (IHCP) participating in the provider network of the Plan to ensure timely access to services available under the contract from such providers for Indian beneficiaries who are eligible to receive services.
- If there are no IHCPs in the county, the Plan must permit Indian beneficiaries to obtain services from an out-of-network IHCP from whom the beneficiary is otherwise eligible to receive such services.

Annual Network Certification Methodology

Network Infrastructure

- Grievances
- Appeals
- Beneficiary Satisfaction
- Policies and Procedures

Future Considerations

- Refining the certification methodology and reporting instructions
- Forecasting utilization
- Timely access monitoring

SMHS
Network Certification
Results

Annual Network Certification

Network Certification Components

- Time and Distance Standards – Geographic Access Maps
- Provider Composition and Capacity
- Mandatory Provider Types – American Indian Health Facilities
- Language Capacity
- Network Infrastructure

Alternative Access Standards

- DHCS Approved AAS for 4 MHPs

MHP Results

2 MHPs passed all five review components: Alpine and Mariposa

Review Component	# MHPs Pass Psychiatry (Adults)	# MHPs Pass Psychiatry (Children)	# MHPs Pass OP SMHS (Adults)	# MHPs Pass OP SMHS (Children)
Time and Distance Standards – Geographic Access Maps	55	55	56	56
Provider Composition and Capacity	19 (current) 12 (FY18/19)	12 (current) 7 (FY18/19)	50 (current) 45 (FY18/19)	41 (current) 33 (FY18/19)

Review Component	Pass	Conditional Pass	Other
American Indian Health Facilities	17	17	22
Language Capacity	50	6	N/A
Infrastructure	49	7	N/A

Corrective Action Plans

- MHPs that did not meet the certification requirements had a Network Adequacy corrective action plan (CAP) imposed.
- An MHP under a CAP must adequately and timely cover SMHS services out-of-network for its beneficiaries.
  - The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.
- DHCS will monitor the Plan's corrective actions and require updated information from the MHP on a monthly basis until such time the MHP is able to meet the applicable standards.

Dental Managed Care

DMC Counties Served

- **2 Counties**
  1) Sacramento – Geographic Managed Care (GMC)
  2) Los Angeles – Prepaid Health Plan (PHP)

- **3 Plans (6 reporting units)**
  1) Access Dental Plan (GMC, PHP)
  2) Health Net of California (GMC, PHP)
  3) Liberty Dental Plan (GMC, PHP)

Projected Enrollment

- DHCS reviewed enrollment trends from the previous three fiscal years and assumed that enrollment within DMC plans would remain consistent with these trends.

	Sacramento (GMC)	Los Angeles (PHP)
Access Dental Plan	136,500	176,604
Health Net of California	129,289	189,506
Liberty Dental Plan	162,191	64,306

COPS-32 Dental Enrollment by Age Report (Enrollment as of 02/02/18)

Network Capacity

- **Provider-to-Member Ratios**
  - Primary Care Dentist (PCD) = 1:2000
  - Total Dentist = 1:1200

- All plans' reported provider networks met and far exceeded the required provider to member ratios. Networks would still have the capacity to serve members even with a substantial increase in projected enrollment.

- DHCS is currently validating plans' reported provider networks by surveying a random sample of providers.

Specialist Network

- **No Mandated Requirement for Specialist Counts**
  However, the following specialist types were incorporated into the total provider count when determining compliance with the required total dentist to member ratio (1:1200):

  - Endodontists
  - Oral Surgeons
  - Orthodontists
  - Pedodontists
  - Periodontists
  - Prosthodontists

- DHCS still evaluated the specialist network for each plan and determined that plans have an adequate network to ensure access to specialty services.

Geographic Distribution

- **Time & Distance Standards**
  - PCD (adults) = 10 miles or 30 minutes
  - PCD (children) = 10 miles or 30 minutes

- DHCS utilized Geographic Information Systems (GIS) software to validate the geographic distribution of PCD provider networks separately for both adults and children.

- CAPs were issued to all 3 plans (6 reporting units) for not meeting the required standard in 2-3 remote zip codes (adults and children). DHCS is closely monitoring the CAPs to ensure full compliance.

- The CAP mandates that out-of-network (OON) access must be provided during the interim period for which the CAP remains open if services cannot be provided in-network within timely access standards.

Timely Access

- **Timely Access Standards (Appointments)**
  - Initial, Routine, and Preventive Care = 4 weeks
  - Specialist (adults) = 30 business days
  - Specialist (children) = 30 calendar days
  - Emergency = 24 hours

- CAPs were issued to Health Net and Liberty for not meeting the required standard for specialist appointments (adults and children) due to not following-up with non-responsive providers. DHCS is closely monitoring the CAPs to ensure full compliance.

- The CAP mandates that OON access must be provided during the interim period for which the CAP remains open if services cannot be provided in-network within timely access standards.

- DHCS is currently validating providers' reported timely access to appointments by surveying a random sample of providers.

DMC Summary

- All plans were deemed conditionally compliant with the network certification requirements found under the Medicaid Managed Care Final Rule.
- For areas where plans were unable to meet one or more standard, DHCS is closely monitoring the plans through the CAP process to ensure full compliance is achieved.
- CAPs have been imposed for Timely Access and Time & Distance.
- All CAPs mandate that OON access must be provided during the interim period for which the CAP remains open if services cannot be provided in-network within timely access standards.
- DHCS continues ongoing efforts to validate plans' reported provider networks and timely access to appointments.

Public Reporting

Public Reporting

- DHCS will post on the website:
  - Letter to CMS - Attestation of network certification compliance
  - Network Certification Results - Assurance of Compliance document
  - Approved Alternative Access Standards
  - CAP findings and Plan responses

Questions/Comments