Managed Care Update

Managed Care Quality and Monitoring Division

Medi-Cal Tribal and Indian Health Program Designee Meeting

Managed Care Quality and Monitoring Division

The Managed Care Quality and Monitoring Division (MCQMD) of the California Department of Health Care Services (DHCS) is responsible for the monitoring and oversight of all Medi-Cal managed care health plans.

- **Branches**: Program Monitoring and Compliance, Policy and Medical Monitoring, and Data Analytics

- **Functions:** plan monitoring, data analysis and reporting, policy development and interpretation, maintenance of the Medi-Cal managed care performance dashboard, encounter data reporting compliance, ensuring network adequacy, and quality improvement efforts

Network Adequacy

To strengthen access to services in a managed care network, the Final Rule required states to establish network adequacy standards in Medicaid managed care for key types of providers, while leaving states the flexibility to set standards. DHCS developed standards including:

- **Time and distance standards**
  - primary and specialty care (adult and pediatric), behavioral health (adult and pediatric), OB/GYN, pediatric dental, hospital, and pharmacy providers
- **Timely access standards**
  - long-term services and supports (LTSS) beneficiaries who travel to the provider to receive services

DHCS will assess and certify the network adequacy of a managed care plan's provider network at least annually.

Final Rule network adequacy requirements are effective in the July 1, 2018 health plan contract year

Network Adequacy Review Process

1. **Provider Counts and Ratios** Primary Care Providers (PCPs), OB/GYNs, Core Specialists, Mental Health Providers, Facilities, Ancillary Services & Managed Long Term Services and Supports (MLTSS)

2. **Mandatory Provider Types**

3. **Time and Distance**

4. **Provider Validations**

5. **Corrective Action Plan Process**

PCPs, OB/GYNs, Core Specialists, Mental Health Providers, Facilities, Ancillary Services & Managed Long Term Services and Supports (MLTSS)

Requirements

- Provider network that is composed of the appropriate range of preventive, primary care, specialty services, and managed long-term services and supports for the expected number of members within the service area.

Approach

- MCPs provide aggregate provider counts for PCPs, OB/GYNs, Core Specialists, Mental Health Providers, Facilities, Ancillary Services and MLTSS if applicable.

Methodology

- Review PCPs, OB/GYNs, Core Specialists, Mental Health Providers by to ensure the MCPs have adequate provider counts based on DHCS' methodology.
- Review ancillary services requirement applied to facilities, individual providers and hospital based services and providers.
- Review facilities and MLTSS by ensuring that the MCPs have a minimum number based on service availability.

Mandatory Provider Types

Requirement

- MCPs must contract with the following provider types or facilities based on contractual, State or federal requirements:
  - At least one federally qualified health center (FQHC), one rural health clinic (RHC) and one freestanding birth center (FBC), where available in the contracted service area
  - Offer contracts with each Indian Health Facility (IHF) in the contracted service area where available
  - Midwifery services made available in the contracted service area

Approach

- MCPs submit a reporting template, which captures the name of the provider or facility, location and contract status.
- MCPs were required to submit an explanation and supporting documentation to justify the absence of the provider type.

Methodology

- Review the MCP's submissions with DHCS data sources and ensured compliance by verifying all differences in the same contracted service area were allowable.
- DHCS ensured that MCPs had attempted to contract with each IHF in their service area.

Time and Distance

Requirement

- Time and distance standards based on county population density applicable to the following provider types: pediatric and adult PCPs, pediatric and adult core specialists, OB/GYN primary care and specialty care services, hospitals, mental health providers, and pharmacies.

Approach

- MCPs submit geographic access maps or accessibility analyses to demonstrate: a). compliance with applicable time or distance standards or b). request alternative access standard for the entire service area.

Methodology

- Review and certify the MCP geographic access maps and accessibility analysis for time and distance standards to ensure coverage of the service are.
- Verify submitted an alternative access standard request based on the geographic access analysis.

Provider Validations

- DHCS validated a sample of each MCP's provider network to ensure there is an executed contract between the provider and MCP.

- DHCS contacted (through email or phone) a random sample of PCPs and core specialists from each MCP's provider network monthly submission.
  - Based on a 90% confidence level and margin of 10% error, DHCS validated a set of 66 random providers from each MCP.

Corrective Action Process

Technical Assistance

- DHCS provided MCPs with technical assistance via email and telephone and worked closely with the MCPs on any identified or potential issues with access.
- After the MCPs' submissions, DHCS continued to provide technical assistance to the MCPs by providing a Pre-CAP worksheet. The Pre-CAP contained findings from DHCS' initial review of the MCP submissions and was intended to allow the MCPs to rectify any findings. The Pre-CAP process helped DHCS determine the MCPs that were unable to meet the standards rather than what was considered to be reporting errors.

DHCS Monitoring

- DHCS will continue to utilize existing quarterly MCP provider network monitoring processes that include, but are not limited to:
  - Quarterly timely access results
  - Investigation of complaints, grievances, appeals and issues of non-compliance
  - A random sample of MCP subcontractor annual network assessments
  - Continuity of care requests
  - Provider-to-member ratios
  - Out-of-Network access requests

Corrective Action Process

- MCPs that were unable to rectify the Pre-CAP findings are subject to a CAP.
- DHCS granted MCPs a conditional pass on Annual Network Certifications if the MCP was unable to meet the network certification requirements.
- DHCS will impose temporary standards for the MCP to meet immediately and impose a CAP for any network certification deficiencies.
- Network Certification CAPs will remain effective until all deficiencies are resolved. MCPs will have up to six (6) months or two quarterly reporting periods to resolve all deficiencies.

Next Steps

- Communicate Alternate Access Standard (AAS) Requests determinations to MCPs
- Review Pre-CAP responses from MCPs
- Issue CAPs for deficiencies
- Submit Assurance of Compliance to CMS by July 1, 2018
- Post AAS approvals and CAPs on DHCS website