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Presentation Roadmap

- SMHS Waiver & STCs
- Medicaid Managed Care Final Rule
  - Consumer Information
  - Network Adequacy
  - Timely Access Standards
  - Grievance and Appeal Systems
- Mental Health and Substance Use Disorder Services Parity
CA’s 1915(b) Freedom of Choice Waiver for Specialty Mental Health Services

- Section 1915(b) Freedom of Choice waiver
  - No choice of providers
  - provide Specialty Mental Health Services (SMHS) using a separate managed care model of service delivery
- The current waiver term is July 1, 2015 through June 30, 2020
  - *Special Terms and Conditions* (STCs) must be met
- DHCS operates and oversees this waiver
- Locally administered by each county's mental health plan (MHP) and each MHP provides, or arranges for, SMHS for beneficiaries

http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medical_Specialty_Mental_Health_Waiver.aspx
STCs in Waiver

• Performance data dashboard
• System to track / measure timeliness of access to care
• Publish Plan of Correction (POC)
• Quality Improvement Plan
• Annual grievance and appeals reports
• Comply w/any changes in federal law, regulation, or policy affecting the Medicaid

http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medical_Specialty_Mental_Health_Waiver.aspx
STC Performance Dashboard Indicators

- **Enrollment data** - unique count of beneficiaries receiving SMHS
- **Demographic data** - by age, gender, race, and ethnicity
- **Penetration rates** - for beneficiaries served and not served, and also arrayed by demographic characteristics
- **Utilization rates** - of services reported by dollar amount, and by service in time increments
- **Time to step-down services** - time to next contact after an inpatient discharge

http://www.dhcs.ca.gov/services/MH/Pages/SMHS_Performance_Dashboard.aspx
**Target Populations and Services**

### Medi-Cal Managed Care Plans (MCP)

**Target Population:**
Children and adults eligible for outpatient non-specialty mental health services (adults w/mild to moderate conditions)

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### County Mental Health Plan (MHP)

**Target Population:**
Children and adults with disabling conditions that require mental health treatment (children; adults w/severe conditions)

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### Non-Specialty Mental Health Services

Carved-in Effective 1/1/14

- **Mental Health Services**
  - Individual and group mental health evaluation and treatment (psychotherapy)
  - Psychological testing when clinically indicated to evaluate a mental health condition
  - Outpatient services for monitoring drug therapy
  - Outpatient laboratory, medications, supplies, and supplements
  - Psychiatric consultation

- **Alcohol Abuse Services**
  - Screening, Brief Intervention, and Referral to Treatment

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### Medi-Cal Specialty Mental Health Services

**Outpatient Services**
- Mental Health Services (assessments, plan development, therapy, rehabilitation and collateral, medication support)
- Day Treatment services and rehabilitation
- Crisis intervention and stabilization
- Targeted Case Management
- EPSDT specialty mental health services

**Inpatient Services**
- Acute psychiatric inpatient hospital services
- Psychiatric Health Facility services
- Psychiatric Inpatient Hospital Professional Services if the beneficiary is in a FFS hospital
Who regulates Medi-Cal plans?

- DHCS
  - Other COHS, PCCMs
  - County Mental Health Plans
- DMHC
  - Denti-Cal Plans
  - 2Plan, GMC, RM, SB, IM Plans + HPSM

NHeLP
NATIONAL HEALTH LAW PROGRAM
MEDICAID MANAGED CARE
FINAL REGULATION
Medicaid Managed Care Rules

• Federal Managed Care Regulations – Part 438 of title 42 Code of Federal Regulations
• Final rule issued May 6, 2016
  • Effective date: **July 5, 2016**
• Phased implementation of new provisions over a 3 year period
  • Network Adequacy (Access Standards): July 1, 2018
  • Grievances and Appeals: July 1, 2017
• Rules apply to PIHPs (**MHPs**) and align with MCOs (**MCPs**)
CONSUMER INFORMATION
Key Information Requirements

• Provider Directories - electronic, paper on request
• Member Handbook – benefits; how and where to get
• Drug Formulary
• Language and format
  • Translation of vital docs, Oral interpretation, Alternative Formats
• Transparency
  • All information available on state website
• Beneficiary Support System – July 2018
• Access to continuity of care – July 2018
  • Also a “parity” issue
Network Adequacy & Access to Care Standards

Time and distance
Timely access to appointments
Network Adequacy

- Requires DHCS to develop and enforce network adequacy standards
- Time and distance standards for providers (adult and pediatric) – e.g. behavioral health
- Must include all geographic areas covered by the managed care program or contract
- States permitted to have varying standards for the same provider type based on geographic area (e.g. rural)
- Requires separate standards for LTSS provider types
Adequate Network

• Sufficient to provide adequate access to all services covered under the contract for all enrollees, including to enrollees with limited English proficiency or physical or mental disabilities
  o Sufficient in number, mix and geographic distribution to meet service area needs
  o Access and cultural considerations
  o Accessibility considerations

• Offers an appropriate range of services that is adequate for anticipated number of enrollees in the service area

• Provides timely access to care
Availability of Services

- State must ensure that all services covered under the State plan are \textit{available and accessible} to enrollees of MHPs \textit{in a timely manner}.

- State must also ensure that MHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68 (\textit{Network Adequacy}).
Provider Selection and Contracting

- **Nondiscrimination**
  - MHPs network provider selection policies and procedures must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

- **Subcontracts**
  - If MHP delegates obligations (contract with the State) to subcontractor, subcontractor must follow all same laws and policies.
Access Standards

• AB 205 – New CA law (Welf. & Instit. Code Section 14197)

• All plans must comply with new time and distance rules starting July 1, 2018
  • Parity between MCPs and MHPs

• MHPs will be required to ensure beneficiaries have timely access
  • Time / Distance to home
  • Days to get appointment with psychiatrist or other mental health provider
# DHCS Core Specialists

<table>
<thead>
<tr>
<th>Specialist Types</th>
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</tr>
</thead>
<tbody>
<tr>
<td>-Cardiology/Interventional Cardiology</td>
<td>-Nephrology</td>
</tr>
<tr>
<td>-Dermatology</td>
<td>-Neurology</td>
</tr>
<tr>
<td>-Endocrinology</td>
<td>-Ophthalmology</td>
</tr>
<tr>
<td>-ENT/Otolaryngology</td>
<td>-Orthopedic Surgery</td>
</tr>
<tr>
<td>-Gastroenterology</td>
<td>-Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>-General Surgery</td>
<td>-Psychiatry</td>
</tr>
<tr>
<td>-Hematology/Oncology</td>
<td>-Pulmonology</td>
</tr>
<tr>
<td>-HIV/AIDS Specialists/Infectious Diseases</td>
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</tr>
</tbody>
</table>
**Time and Distance Standards**

- Primary care, adult and pediatric
- OB/GYN
- **Behavioral health (mental health and substance use disorder), adult and pediatric**
- Specialty care, adult and pediatric
- Hospital
- Pharmacy
- Pediatric dental
- Additional provider types determined by CMS
Time and Distance Standards – Mental Health Services – beginning July 1, 2018

- **Standards** vary by county size:
  - (Rural): 60 miles/90 minutes from beneficiary’s residence
    - Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne
  - (Small): 45 miles/75 minutes from beneficiary’s residence
    - Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba
  - (Medium): 30 miles/60 minutes from beneficiary’s residence
    - Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura
  - (Large): 15 miles/30 minutes from beneficiary’s residence
    - Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara
## Timely Access to Appointments

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care appointments that do not require prior authorization</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent care appointments that do require prior authorization</td>
<td>96 hours</td>
</tr>
<tr>
<td>Non-urgent <em>primary care</em> appointments</td>
<td>10 business days</td>
</tr>
<tr>
<td>Non-urgent <em>specialist (Psychiatry)</em></td>
<td>15 business days</td>
</tr>
<tr>
<td>Non-urgent mental health provider (non-psychiatry)</td>
<td>10 business days</td>
</tr>
<tr>
<td>Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health conditions</td>
<td>15 business days</td>
</tr>
<tr>
<td>Telephone wait time</td>
<td>No more than 10 minutes</td>
</tr>
<tr>
<td>Normal business hours</td>
<td>Standards</td>
</tr>
<tr>
<td>Triage – 24/7 services</td>
<td>24/7 services; Call back time is no more than 30 minutes</td>
</tr>
</tbody>
</table>
**Timely Access - Limited Exceptions**

<table>
<thead>
<tr>
<th><strong>Extended Appointments</strong></th>
<th><strong>Periodic Office Appointments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• If referring or treating provider has determined a longer wait time will not have a detrimental impact on the health of the beneficiary*</td>
<td></td>
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<tr>
<td>• Must be noted in the beneficiary’s record</td>
<td></td>
</tr>
<tr>
<td>• Visits to monitor and treat mental health conditions may be scheduled in advance*</td>
<td></td>
</tr>
</tbody>
</table>

* consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice
Alternative Access Standards

• MCPs and MHPs can request alternative standards
• Must be approved by DHCS
  • reasons justifying the alternative standard
  • use DHCS template and process
• Proposed alternative standard shall be approved/denied
  • Within 90 days of request
  • By zip code / Service type
  • Valid for one fiscal year
• Time/distance doesn’t apply where in-home or community based services (still must be timely)
Community-Based Services/ Mobile Services/Telehealth

• **Community-Based and Mobile Services**
  • May be provided anywhere in the community
  • DHCS will consider a substitute standard (other than time and distance) when provider travels to the beneficiary and/or a community-based setting to deliver services
  • Plan must ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the beneficiary’s individualized client plan

• **Telehealth**
  • Plans are permitted to use telehealth to meet network adequacy standards and/or as a basis for alternative access requests
  • must comply with DHCS’ Medi-Cal Provider Manual telehealth policy
Out-of-network rules

• All MHPs must provide access to out-of-network services in cases of emergency

• When medically necessary services are “unavailable” in the MHP’s network, plans must provide access to services out-of-network at no additional cost to the enrollee
Grievance and Appeals

Notice and the Right to a Hearing in Medi-Cal
Grievance and Appeal Systems

• The MHP must have a grievance and appeal system that meets the requirements of regulations

• The State must conduct random reviews of each MHP and its providers/subcontractors to ensure they are notifying enrollees in a timely manner
Handling of Grievances and Appeals

- MHP must assistance enrollees to complete forms and with other procedural steps related to a grievance or appeal

- Includes auxiliary aids and services upon request,
  - providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability

- Recordkeeping of each grievance/appeal
Process to Appeal Adverse Benefit Determinations

- Notice of ABD
- DMHC Complaint
  - Not MHPs
- IMR
  - Not MHPs
- Notice of Resolution
- Step 1
  - Plan Internal Appeal
- Step 2
  - State Fair Hearing
Appeals

Action = **Adverse Benefit Determination** =

- Denial, reduction, suspension, termination, delay of service
- Denial/limited approval based on medical necessity, appropriateness, type, level, setting or effectiveness
- Disputes involving cost sharing
- Failure to act within timeframe for standard grievances

438.400(b)
Grievance

• An expression of dissatisfaction about any matter other than an adverse benefit determination

• Can be filed *any time*

• Oral or written

• Plan Resolution: w/i 90 calendar days of receipt

• Plan to provide written acknowledgement within 5 days
Notice of Adverse Benefit Determination

Timing

• **Terminations, Reductions, Suspensions**: plan must provide notice at least **10 days in advance** of the decision effect date.

• **Denial, delay, or modification** of all or part of the requested specialty mental health service request: **within 2 business days** of decision /as expeditiously as condition requires (not to exceed 14 days) (**APL 17-006; MHSUDS IN 18-010**)

• **Denial of payment**, **at the time** of any action denying the provider’s claim.
Contents of the Notice

• Action the plan intends to take or has taken

• Reasons for the decision
  • if medical necessity, the notice must include the clinical reasons for the decision
  • explicitly state why beneficiary’s condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria

• Criteria or guidelines used
  • includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations

• Access to and free copies of all documents/information relevant to the decision

• Right to appeal information
Model NOABDs [MHSUDS IN 18-010]

- Denial of authorization for requested services
- Denial of payment for a service rendered by provider.
- Delivery system
  - determination that beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan
- Modification of requested services Use this template
- Termination of a previously authorized service
- Delay in processing authorization of services
- Failure to provide timely access to services
- Dispute of financial liability
Step 1: Internal Plan Review

Appeal
• Review of an Adverse Benefit Determination
  • Must request *within 60 days of notice*

Grievance
• *Expression of dissatisfaction about any matter not an adverse benefit determination*
  • Can request at any time
Benefits Continuing during Appeal

- Only available for cases involving a termination, reduction, or suspension of service

- Must request continuing benefits within 10 days of the notice date or before the proposed change

- Benefits continue until appeal is resolved favorably (may request again at fair hearing stage)
  - Must request BEFORE original authorization period expires
Expedited Internal Plan Review

- provider indicates or plan determines that: the standard timeframe may seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function
Internal Plan Review: Process

• Plans must:
  • Ensure that decision-maker:
    • (1) has the ability to require corrective action,
    • (2) was not involved in any prior decisions on the case, and
    • (3) has appropriate clinical expertise in treating condition
  • Provide the enrollee the opportunity to present evidence, and allegations in person and in writing
  • Allow the enrollee (or representative) to examine any case records
  • Resolve grievances and appeals within time required by enrollees health condition, but no more than 30 days
Notice of Appeals Resolution (NAR)

- Timeframe for resolution
  - Standard cases: 30 days
  - Expedited cases: 72 hours
  - Time may be extended by 14 days if requested by beneficiary or delay is in beneficiary’s interest
    - provide written notice of the extension within two calendar days
NAR Content

• If Adverse Benefit Determination is **upheld**:
  • Result of the appeal and the date of decision
  • Criteria, clinical guidelines or policies used
  • Explanation that:
    • Enrollee also has the right to a Medi-Cal fair hearing
    • Enrollee has the right to continue benefits, and how to do so

• If Adverse Benefit Determination **overturned**:
  • clear and concise explanation of the reason

*Note*: plan must authorize or provide the disputed services promptly *(no longer than 72 hours)*
Step 2: External Review

• When?
  • Adverse Benefit Determination or other plan decision is upheld or not resolved 100% in the enrollee’s favor

• What?
  • State Fair Hearing

• Time limit?
  • For adverse benefit determinations, must file for hearing within 120 days of the NAR (unless good cause)

Note: For grievances that are not an adverse benefit determination, generally must file within 90 days of the event at issue (including time spent in grievance) but DHCS guidance is limited
Expedited External Review

• **When Eligible for Expedited Review:**
  - When standard timeframe may seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function.

• **State Fair Hearing**: resolve *within 3 business days of request*, or quicker if required by the enrollee’s health condition.
External Review: Exhaustion

• Enrollees must exhaust the plan’s internal review process before they can proceed to external review
  • *Deemed exhaustion*: when plan fails to provide adequate notice or follow grievance/appeal rules, or does not resolve grievance/appeal within 30 days
  • Exception: urgent cases
State Fair Hearing - process

• Review by an Administrative Law Judge employed by CDSS

• Review any action or inaction by state/county/plan related to Medi-Cal eligibility or benefits, such as:
  • Denial of benefits/failure to act with reasonable promptness
  • Reduction, suspension, termination of services
  • Transfer or discharge from SNF

• **BUT NOT:** if sole issue is federal or state law and:
  • Enrollee does not question that the law has been correctly applied
  • A change in the law requires a reduction in Medi-Cal benefits
Resolution at State Fair Hearing

- **Standard cases**: A decision within **90 days of hearing request**

- **Expedited cases**: **Within 3 business days**, or quicker if required by the enrollee’s health condition

- Plan must **implement the decision within 72 hours**, or quicker if required by the enrollee’s health condition
Mental Health Plan Appeal

Adverse Benefit Determination
- Notice must be provided at least 10 days prior to action
- Enrollee has up to 10 days to request continued benefits

Plan Internal Appeal
- Decision within 30 calendar days after plan receives appeal
- Only one level permitted

State Fair Hearing
- Decision within 90 days post filing
- “Deemed exhaustion”

Individual has up to 60 calendar days from date on notice to file

Individual has up to 120 days to request fair hearing after plan decision

No State option for direct path to SFH w/o in-plan exhaustion
After State Fair Hearing Resolution

• DHCS Director must adopt or alternate *proposed decision* by DSS ALJ within 30 days (3 if expedited)

• *Rehearing* is available at the state’s discretion
  • Must request *within 30 days* of hearing decision

• Enrollee can go to state or federal court
Beneficiary Problem Resolution – Grievances and Appeals

✔ Right to file a **grievance**
  - Complaint re quality of services or other issues

✔ Right to file an **appeal**
  - Any *Adverse Benefits Determination*
  - Right to a “state fair hearing”
    - Must appeal to plan before can get a hearing

✔ Consumers who need help?
  - Health Consumer Alliance: (888) 804-3536
  - [www.healthconsumer.org](http://www.healthconsumer.org)
Grievance & Appeals – Resource & DHCS Guidance to MCPs and MHPs

- **AB 205 (Wood) -** Welf. & Instit. Code § 14197.3; 10951(b); 10951.5

- **APL 17-006 (released 5/9/17)**

- **MHSUDS Information Notice 18-010E (released 3/27/18)**
PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES
Mental Health Parity Requirements

- Mental health and substance use disorder services cannot be more restrictive than medical/surgical services
  - Applies to Medi-Cal managed care plans

- Services
  - Inpatient, outpatient, emergency and prescription drugs

- Alignment of rules / policies between MCPs & MHPs
  - Areas include
    - Grievances and appeals
    - Network adequacy
    - Continuity of care
Mental Health Parity Requirements: MCPs/MHPs

**Contract Alignment**

**Quantitative Treatment Limits (QTL)**

**Non-Quantitative Treatment Limits (NQTL)**

- Network Adequacy ✓
- Grievances and Appeals ✓
- Authorization process and timeframes for SMHS ~ 7/2018
- Continuity of Care ~ 7/2018
QUESTIONS

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THANK YOU