Managed Care Final Rule and Parity Final Rule

California Department of Health Care Services
Mental Health and Substance Use Disorder Services

California Quality Improvement Coordinators Annual Meeting
March 14, 2018

Presentation Outline

- Network Adequacy
- Authorization of SMHS
- Continuity of Care
- Screening and Enrollment of SMHS Providers
- Managed Care Quality Strategy
- Questions and Open Discussion

Network Adequacy

Network Adequacy Announcements

- **MHSUDS Information Notice 18-011 (Issue date: February 13, 2018)**
  - Enclosure 1 – Network Adequacy Certification Tool (**contact DHCS for this Enclosure**)
  - Enclosure 2 – Network Certification Checklist
  - Enclosure 3 – Alternative Access Standards Request

Network Adequacy Requirements

Network Adequacy Standards*

- Psychiatry
- Outpatient Mental Health Services
- Outpatient SUD Services (Non-OPD)
- Opioid Treatment Programs (OPD)

Reporting & Transparency

- Annual Program Assessment Report
- Website posting of network adequacy standards and alternative access requests/approvals

Annual Network Certification

- Conduct network certification review
- Submit assurance of compliance to CMS

* Adult and pediatric

Network Adequacy Standards

For psychiatry, the standards are as follows:

Timely Access	Within 15 business days from request to appointment
Time and Distance	**Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: 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.
	Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Network Adequacy Standards

The standards for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services are as follows:

Timely Access	Within 10 business days from request to appointment
Time and Distance	**Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: 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.
	Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Network Adequacy Standards

For outpatient SUD services, other than opioid treatment programs (OTPs), the standards are as follows:

Timely Access	Within 10 business days from request to appointment
Time and Distance	**Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

Network Adequacy Standards

For OTPs, the standards are as follows:

Timely Access	Within 3 business days from request to appointment
Time and Distance	**Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: 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.
	Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Appointment Time Standards

- Urgent care appointment for services that do not require prior authorization – within **48 hours** of a request
- Urgent appointment for services that do require prior authorization – within **96 hours** of a request
- Non-urgent appointment with a non-physician mental health care provider – within **10 business days** of request
- Non-urgent appointment with a psychiatrist – within **15 business days** of request
- Opioid treatment program – within **3 business days** of request

Appointment Time Exceptions

- The applicable appointment time standards may be extended if the referring or treating provider has determined and noted in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary
- Periodic office visits to monitor and treat mental health conditions may be scheduled in advance 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

1. Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(G)

Network Adequacy Documentation

Plans must submit the following:

- Network Adequacy Certification Tool (NACT)
- An alternative access request, if applicable
- Geographic access maps
- Accessibility and access summary chart
- Language line utilization chart

Network Adequacy Certification Tool (NACT)

- **Exhibit A-1:** Network Provider Data, Organizational/Legal Entity Level
- **Exhibit A-2:** Network Provider Data, Provider Site Detail
- **Exhibit A-3:** Network Provider Data, Rendering Provider Detail
- **Exhibit B-1:** Community Based Services
- **Exhibit B-2:** American Indian Health Facilities
- **Exhibit C-1:** Provider Counts
- **Exhibit C-2:** Expected Service Utilization

NACT Exhibits A 1-3 Network Provider Data

- **Each Plan shall complete the NACT for all network providers:**
  - Organizational level (provider's legal entity)
  - Site level (physical location/site of the provider)
  - Rendering Provider (individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries)
- **Network providers include:**
  - County-owned and operated providers
  - Contracted organizational providers
  - Provider groups
  - Individual practitioners

Alternative Access Standards

- **Alternative access requests may be allowed for time and distance standards if**:
  - 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.
- **Alternate Access considerations include, but are not limited to the following:**
  - Seasonal considerations
  - Availability of community-based and mobile services
  - Availability of telehealth services

Supporting Documentation

Plans must submit the following:

- Grievances and appeals
- Provider agreements boilerplates for network providers and subcontractors, including agreements for interpretation, language line, and telehealth services
- Plan's provider directory/directories (MHPs Only)
- Results of beneficiary satisfaction surveys related to network adequacy or timely access (MHPs Only)

Policies and Procedures

- **Network adequacy monitoring**
  - Submit policies and procedures related to the Plan's procedures for monitoring compliance with the network adequacy standards.
- **Out of network access (MHPs Only)**
  - Submit policies and procedures related to the provision of medically necessary services delivered out-of-network.
- **Timely access**
  - Submit policies and procedures addressing appointment time standards
- **Service availability**
  - Submit policies and procedures addressing requirements for:
    - Appointment scheduling
    - Routine specialty (i.e., psychiatry) referral
    - After-hours calls

Policies and Procedures

- **Physical accessibility**
  - Submit policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990.
- **Telehealth services**
  - Submit policies and procedures regarding use of telehealth services to deliver covered services.
- **24/7 Access line requirements**
  - Submit policies and procedures regarding requirements for the Plan's 24/7 Access Line
- **24/7 language assistance**
  - Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

Submission Requirements

- Plans shall submit the initial NACT and supporting documentation no later than **March 30, 2018**
- No flexibility with submission deadline
- Subsequent MHP submissions due quarterly:
  - **July 1**
  - **October 1**
  - **January 1**
  - **April 1**
- Operating DMC-ODS counties are required to submit NACTs annually on **April 1st**

Significant Change Requirement

- Plans are required to notify DHCS any time there has been a significant change in the Plan's operations or network composition that would affect the adequacy and capacity of services.
- Plans must notify DHCS within 10 business days if there is any loss of a network provider (e.g., psychiatrist(s) serving children/youth).

Network Certification

Network Adequacy Data Validation

- DHCS will utilize various data sources (e.g., claims data, enrollment data, eligibility data, provider files) to validate county provider data, service utilization, and network composition.
- DHCS will also require deliverables submissions.

Technical Assistance and Corrective Action

- DHCS will provide technical assistance to Plans regarding requirements to demonstrate network readiness and enforce any corrective action needed as needed.

Network Certification

- DHCS will submit Network Adequacy Certifications to CMS annually on July 1st as required by the Final Rule.
- Network adequacy data and approved alternative access standards will be posted on DHCS' website and detailed in the Annual Program Assessment Reports.

DMC-ODS Network Certification

Certification Process Approach

- DHCS will utilize a Pre-Implementation Certification Process to evaluate network adequacy for any DMC-ODS county that goes live between July 1, 2017 and June 30, 2018.
- Any county that goes live after June 30, 2018 will need to use the network adequacy certification requirements in the Information Notice 18-011.

Post-Implementation Certification

- The six DMC-ODS counties that went live prior to July 1, 2017 will complete the NACT and need to meet the submission deadlines as identified in the Information Notice 18-011.
- The six counties are Riverside, San Mateo, Marin, San Francisco, Contra Costa, and Santa Clara.

DMC-ODS Network Certification

Pre-Implementation Certification Components

- Projected Utilization based on estimates from historic utilization and prevalence data from the DMC-ODS County implementation plans.
- Determine the number of providers needed to serve the projected utilization, also from the DMC-ODS County implementation plans.
- Develop time and distance mapping based on both actual DMC enrollment and Medi-Cal enrollment for the DMC-ODS County using current provider lists made available at the time of the readiness review.

Compliance with Submission Deadline

- Submission is a condition for receiving Federal Financial Participation
- Submission deadline is **Friday, March 30, 2018**
- There is **no flexibility** with the submission deadline
- DHCS may impose financial sanctions if Plans fail to submit complete, accurate and timely

Non-Compliance with Network Adequacy Standards

- If Plans are not in compliance with network standards **at the time of submission** to DHCS:
  - Plans will be required to submit a Plan of Correction (POC) to demonstrate action steps that the Plan will immediately implement to ensure compliance with the standards no later than July 1, 2018
  - Plans must provide updated information on a bi-weekly basis until the Plan is able to meet the applicable standards.

Non-Compliance with Network Adequacy Standards

- If the Plan is not in compliance with the applicable standards **by July 1, 2018**, DHCS may impose additional corrective actions, including:
  - Administrative or financial sanctions, or,
  - Any other actions deemed necessary to promptly ensure compliance
- For as long as the Plan is unable to meet standards in its network, the Plan must also adequately and timely cover these services out-of-network for the beneficiary

County Considerations – Network Adequacy

- **Orange**
  - NACT –
    - Short Term, Intermediate Term, Long Term Approaches
    - Small work teams
    - Challenges
    - Opportunities
  - Time and Distance Standards
    - Challenges – Minimal. Small geographically so good coverage.
    - Opportunities – Review beliefs regarding coverage.
  - Timely Access Requirements
    - Challenges – Data capture. Operationalizing. Staff training. 48 hour urgent on Friday
    - Opportunities

- **Other Counties?**

Parity in Authorization of SMHS

Medicaid Parity Rule

Background and Purpose

- Parity Rule was issued on March 30, 2016
- Applies certain requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to the Medicaid program
- Medicaid Managed Care Regulations, Part 438, subpart K

Scope of Application

- All individuals enrolled in a Medi-Cal managed care organizations (MCO)
- Once the beneficiary is enrolled in an MCO, his/her entire benefit package is subject to parity including MH, SUD and/or FFS

Compliance Date

- October 2, 2017

Medicaid Parity Rule

Parity Requirements

- Aggregate lifetime and annual dollar limits
- Financial requirements (FRs)
- Quantitative treatment limitations (QTLs)
- Non-quantitative treatment limitations (NQTLs)
- Information requirements

Four Benefit Classifications

- Inpatient
- Outpatient
- Prescription Drugs
- Emergency Care

Authorization Overview

- Concurrent Authorization: Inpatient Psychiatric Hospital Services and Psychiatric Health Facilities
- MHP Referral/Prior Authorization: Outpatient SMHS
- Retrospective Authorization No Longer Allowable
- Currently finalizing policy and Information Notice

Concurrent Authorization

- Effective July 1, 2018, required concurrent review of treatment authorizations following the first day of admission through discharge
- Applies to psychiatric inpatient hospital services and psychiatric health facility (PHF) services
- Acute and administrative day authorizations
- Decisions to approve, modify, or deny requests shall be communicated to the beneficiary's treating provider within 24 hours of the decision.
- May authorize multiple days, but each day of treatment must meet the same medical necessity criteria and may not be denied retrospectively

MHP Referral /Prior Authorization

- Effective July 1, 2018, required referral or prior authorization of specified SMHS
- Prior authorization decisions within five (5) business days after receiving the request.
- Expedited authorization decisions no later than 72 hours after receipt of the request for service.
- MHPs shall act on an authorization request for treatment for urgent conditions within one hour of the request.

MHP Referral /Prior Authorization

- PROPOSED: MHP referral or prior authorization is required for the following services:
  - Adult Residential
  - Crisis Residential
  - Day Treatment Intensive
  - Day Rehabilitation
  - Therapeutic Behavioral Services
  - Therapeutic Foster Care

MHP Referral /Prior Authorization

- PROPOSED: MHP referral or prior authorization is not required for the following services:
  - Mental Health Services
  - Medication Support Services
  - Targeted Case Management
  - Intensive Care Coordination
  - Intensive Home-Based Services

MHP Referral /Prior Authorization

- PROPOSED: MHP referral or prior authorization cannot be required for the following services:
  - Crisis Intervention
  - Crisis Stabilization
  - Assessment

MHP Flexibility

- MHPs may choose to require MHP referral or prior authorization for additional modes of service that are not required by DHCS.
- MHPs may require providers to request payment authorization for the continuation of services at intervals specified by the MHP (i.e. every six months).
- MHPs must notify DHCS of any changes to their referral or prior authorization policies that exceed the minimum requirements established by DHCS.
- All beneficiary informing materials should be amended accordingly to disclose and explain all referral and prior authorization requirements to beneficiaries.

County Considerations - Authorization of SMHS

- **Orange**
  - Challenges - Understanding/defining processes. Staffing. No central authorization team so coordinating logs/reporting/etc.
  - Opportunities – Improved utilization of limited resources. Decreased likelihood of recoupments.

- **Other Counties**

Parity in Continuity of Care Requirements

Continuity of Care

- Medi-Cal beneficiaries have the right to request continuity of care (CoC)
- Beneficiaries with pre-existing provider relationships must be given the option to continue treatment with an out-of-network Medi-Cal provider or a former network provider
- CoC arrangements not to exceed 12 months

Policy Application

- CoC requirements apply to all Medi-Cal beneficiaries who are transitioning into the SMHS delivery system, as follows:
  - From one county MHP to another county MHP due to a change in the beneficiary's county of residence
  - From an MCP to an MHP
  - From Medi-Cal FFS to an MHP

CoC Conditions

- Documented pre-existing relationship between beneficiary and provider
- The provider is eligible under State Plan and State law
- The provider agrees, in writing, to be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers
- The provider agrees, in writing, to comply with State requirements for SMHS, including documentation requirements

CoC Conditions

- The provider supplies the MHP with all relevant treatment information, for the purposes of determining medical necessity
- The provider is willing to accept the higher of either the MHP's provider contract rates for existing network providers or Medi-Cal FFS rates;
- The provider does not have disqualifying quality of care issues to the extent that the provider would not be eligible to provide services to any other beneficiaries of the MHP.

County Considerations – Continuity of Care

- **Orange**
  - Challenges – Low frequency event. Ensuring provider understands requirements. Monitoring services if out of county. Questions regarding claiming.
  - Opportunities – Improved client experience of care, with possible improved outcomes.

- **Other Counties**

Screening and Enrollment of SMHS Providers

Federal Requirements

- 42 CFR 438.602(b) and 42 CFR 438.608(b) require all Medi-Cal providers to be enrolled with DHCS and screened in accordance with 42 CFR Part 455, subparts B & E
- 21st Century Cures Act required enrollment as of January 1, 2018
- MHSD is currently working with DHCS' Provider Enrollment Division to establish enrollment procedures for SMHS providers
- Information Notice forthcoming

Screening and Enrollment Components

- Network Provider Agreements
- Ownership and Control Disclosures
- Screening Activities Based on Categorical Risk Levels (low, moderate, high)
- Federal Database Checks
- Site Visits
- Fingerprinting and Criminal Background Checks
- Revalidation of Enrollment

County Considerations – Screening and Enrollment of Providers

- **Orange**
  - Challenges - Questions on the requirements. Understanding interaction with pending credentialing requirements.
  - Opportunities – Utilize NACT provider list.

- **Other Counties**

Managed Care Quality Strategy

Quality Strategy Report Overview

I. Overview of Managed Care Delivery Systems
II. Network Adequacy and Availability of Services
III. Evidence-Based Clinical Practice Guidelines
IV. Continuous Quality Improvement
V. External Independent Reviews
VI. Transition of Care Policy
VII. Reducing Health Disparities
VIII. Sanctions

Managed Care Quality Strategy

- **Orange**
  - Challenges – Needing more information. Practice Parameters (guidelines) need expansion and review. Moving the needle. New data needed for ongoing timely access measurement.
  - Opportunities – Identify needs. Develop action plan.

- **Other Counties**

Questions?

- For questions regarding Final Rule and/or Parity, please contact **MHSDFinalRule@dhcs.ca.gov**
- For DMC-ODS specific questions, please contact: **DMCODSWaiver@dhcs.ca.gov**
- For technical questions about Network Adequacy data submission, please contact **NACTData@dhcs.ca.gov**