

CMS' Medicaid Managed Care Final Rule:

Updates & Implementation

**Department of Public Health
San Francisco Health Network
Behavioral Health Services (BHS)
San Francisco Mental Health Plan (SFMHP)
San Francisco Drug Medi-Cal/
Organized Delivery System Waiver (DMC-ODS Waiver)**

June 2018



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Final Rule Overview

“Medi-Cal Insurance”

**Physical Health
Medi-Cal**

**San
Francisco
Health
Plan**

**Blue
Cross
Partner.
Plan**

- Physical health care
- Mild/Moderate MH care
- Autism Spectrum/BHT

**Mental Health
Medi-Cal**

**BHS
(County
MHP)**

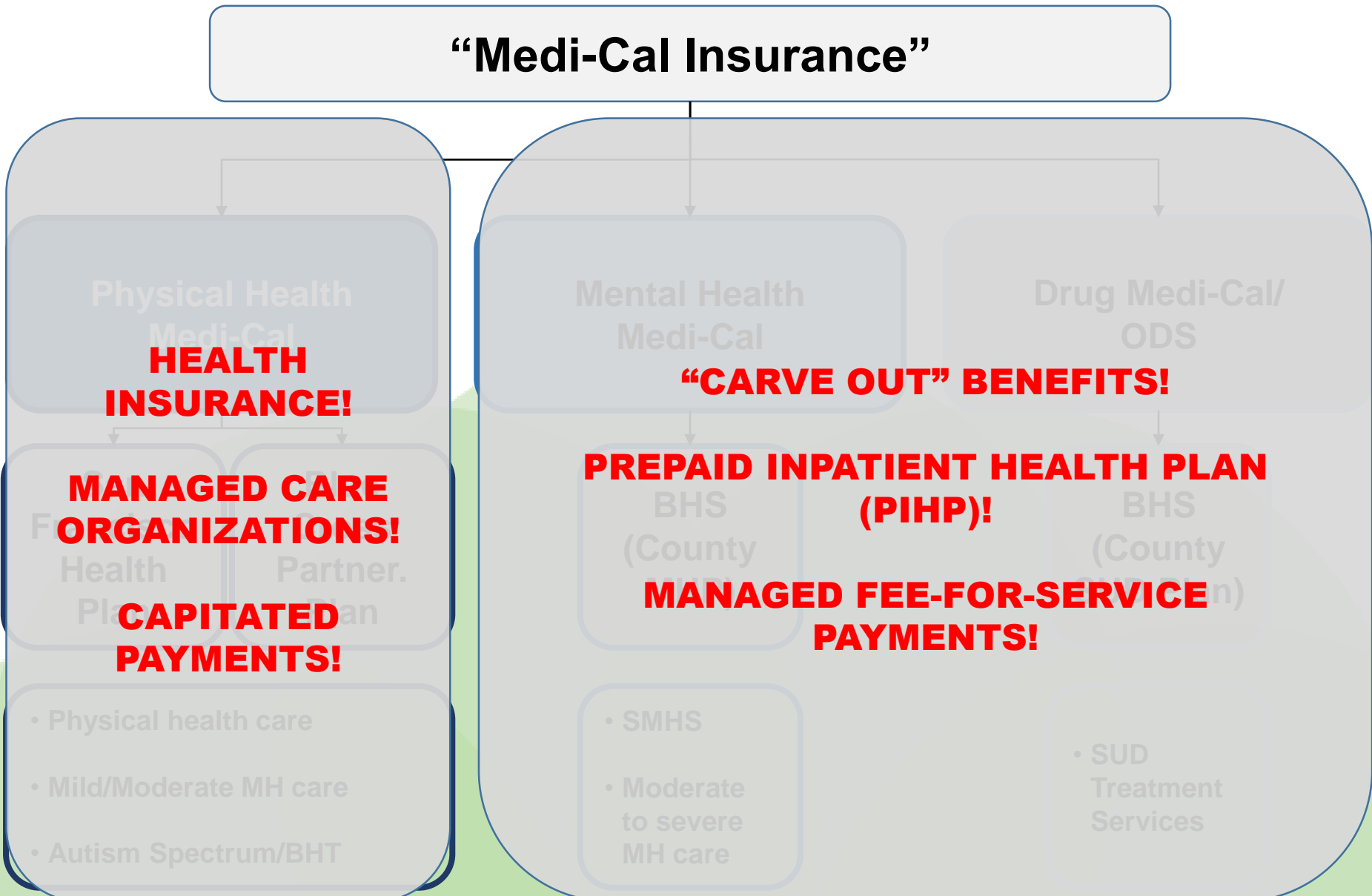
- SMHS
- Moderate to severe MH care

**Drug Medi-Cal/
ODS**

**BHS
(County
SUD Plan)**

- SUD Treatment Services

Final Rule Overview



Final Rule Overview

• How Did We Get Here

- Continuing Trajectory of the Affordable Care Act (ACA):
 - Standardized Essential Benefits
 - Standardized Regulations
- Growth of Managed Care:
 - Upsides (ability for a state to predict/project/manage budgets with predictability)
 - Downsides (financial incentives could lead to narrow networks, lack of access/quality)
- Consumer Protections:
 - Medicaid State Agency/DHCS responsibility to beneficiaries
 - Beneficiaries able to access/understand/use service system

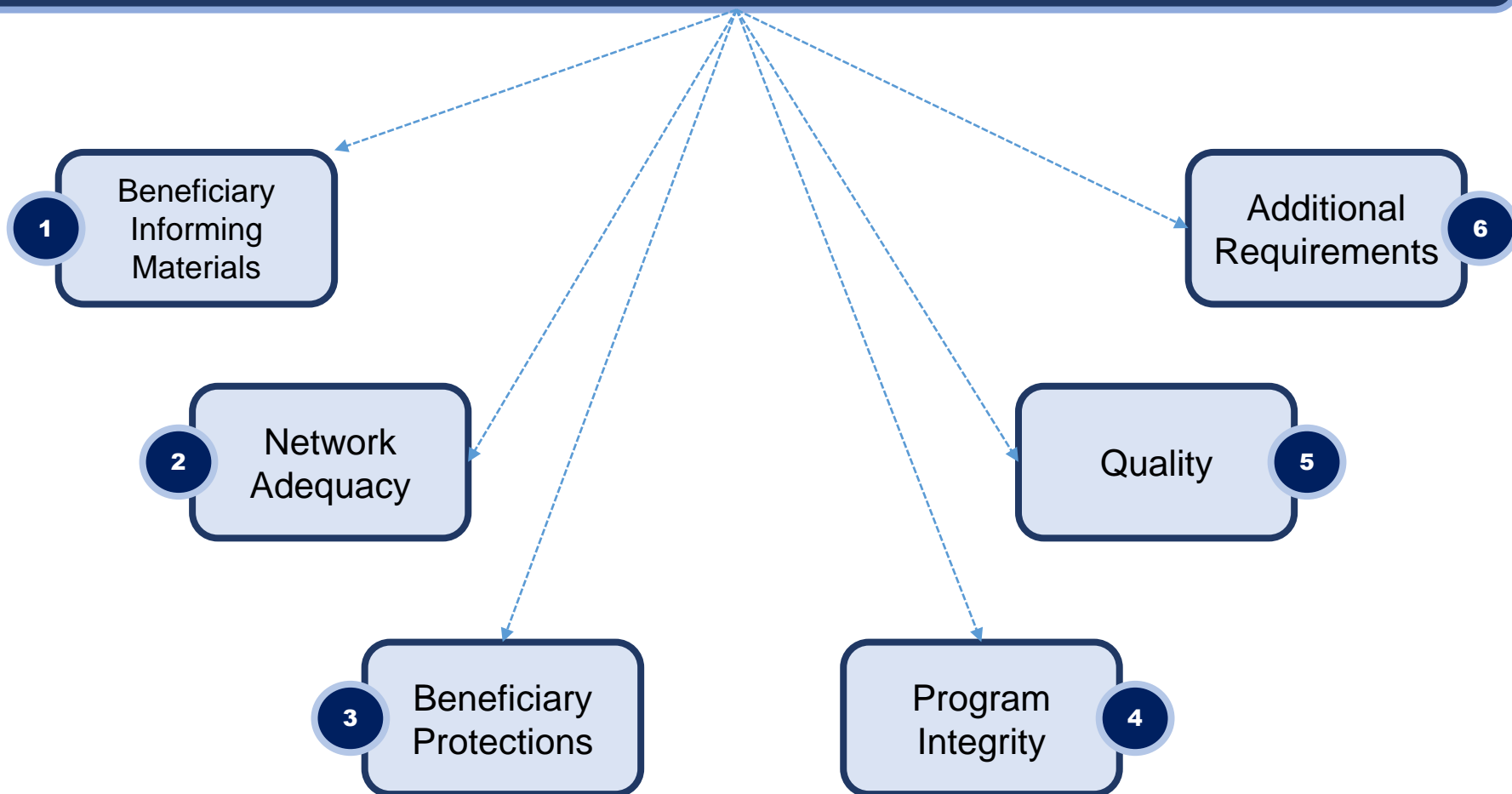
Final Rule Overview

• How Did We Get Here (continued)

- Characteristics and Needs of the Medicaid Population:
 - Less likely to be connected to health provider
 - More likely to have multiple needs (MH, SUD, Physical)
 - Disabling consequences of behavioral health disorders (living/housing; vocational/educational; community integration).
- Parity:
 - Loopholes in prior parity legislation
 - Must comply with “Parity in Mental Health & Substance Use Disorder Services Final Rule” (March 30, 2016; 81.Fed.Reg. 18390)
 - Aligns with commercial insurance requirements under the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA)

Final Rule in Pictures

Six Domains for the Final Rule



Final Rule in Words

Beneficiary Informing Materials	Network Adequacy	Beneficiary Protections	Program Integrity	Quality	Additional Requirements
<ul style="list-style-type: none"> • Beneficiary Handbook • Provider Directory • Drug Formulary • Website • Grievance/ Appeals & Denials/ Termination Notices • Taglines • Translation, Alternative Formats, Aids 	<ul style="list-style-type: none"> • Availability of Services • Assurances of Capacity • Time/Distance Standards • Timely Access (& Alternative) Standards • Provider/ Service Capacity • Language & Physical Accessibility 	<ul style="list-style-type: none"> • Grievance/ Appeals System • Coverage and Authorization of Services • Continued Services to Enrollees 	<ul style="list-style-type: none"> • Compliance Program • Conflict of Interest Safeguards • Credentialing • Disclosure of Info by Providers/ Fiscal Agents • Prohibited Affiliations and Excluded Providers • Fraud 	<ul style="list-style-type: none"> • Quality Assessment and Performance Improvement Program • Quality Strategy • EQRO • Quality Rating System 	<ul style="list-style-type: none"> • Record Keeping and Inspection • Coordination & Continuity of Care • Subcontract Relationships & Delegations • Health Information Systems • Encounter Data • Parity
1	2	3	4	5	6

Final Rule in Stories



DHCS, the Medicaid State Agency



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SFDPH, the Managed Care Plan

Final Rule in Stories



Example Agency, the Organizational Provider



Natalie, the Staff



Luciano, the Beneficiary/Client

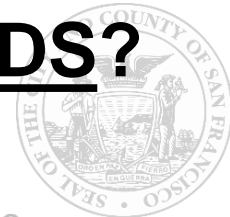
Final Rule in Stories

- **What's Different for DHCS, the State Medicaid Agency?**



- Need to standardize contracts across types of Medicaid “managed care” contracts
 - Managed Care Organizations (**MCO/San Francisco Health Plan**)
 - Prepaid Inpatient Health Plans (**PIHP/SFDPH-BHS**)
- Need to standardize beneficiary protection systems (e.g., timeframes for grievance, appeals, etc.)
- Need to analyze and validate the adequacy of provider networks for each “Managed Care Plan/Mental Health Plan”

Final Rule in Stories

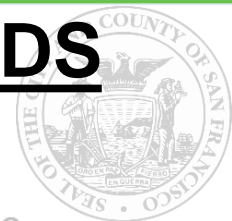


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• What's Different for SFDPH, the MHP/DMC-ODS?

- Needs to update/maintain new Information Requirements (handbook, provider directory, etc.) **1**
- Needs to monitor/report Network Adequacy (timeliness, caseloads and staff types, etc.) **2**
- Needs to monitor clients' rights, access and utilization (grievances, timely authorizations, etc.) **3**

Final Rule in Stories



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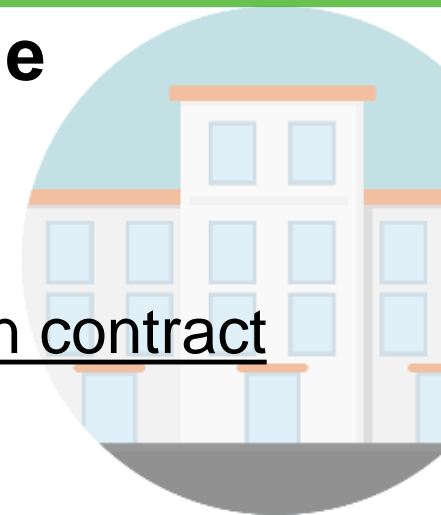
- What's Different for SFDPH, the MHP/DMC-ODS (continued)?

- Needs to implement new compliance elements including credentialing, excluded providers and fraud monitoring 4

- Needs to implement new quality elements (e.g., quality strategy, EQRO, etc.) 5

- Needs to implement additional new elements (e.g., record keeping, parity, etc.) 6

Final Rule in Stories



- **What's Different for Example Agency, the Organizational Provider**
 - Needs to get Medi-Cal certified and create/sign contract documents (4) (6)
 - Needs to display posters and signs regarding Medi-Cal clients' rights (3)
 - As needed, accesses centralized resources for clients who need language translation and/or alternative formats of information (e.g., large size print) (1)
 - Needs to maintain records for a specified length of time (6)

Final Rule in Stories

• What's Different for Natalie, the Staff?



- Needs to get credentialed with SFDPH and obtain a billing ID number **4**
- Needs to be trained in health care compliance, privacy **4**
- Needs to provide and explain information to clients about their rights, responsibilities and benefits **1**
- Needs to document and negotiate “bumps” in the process (e.g., Notice of Adverse Beneficiary Determination) **3**

Final Rule in Stories

- **What's Different for Luciano, the Client?**



- Needs to understand his insurance benefits and also communicate with BHS about needs/rights **1**
- Needs to find a qualified provider, contact the provider and get a timely initial appointment **2**
- Needs to receive initial assessment for medical necessity for SMHS and request a second opinion, as needed **3**

General Informing Materials Requirements

- Applies to:

Beneficiary Handbook

Provider Directory

Drug Formulary

Grievance and Appeal Forms

Notices of Adverse Benefit Determination

BHS Website

- Font Size:

Normal	Large
No smaller than 12 point	No smaller than 18 point

- Language: Available in all 6 threshold languages and other non-threshold languages upon request and at no cost to the client
- Alternate Formats and Auxiliary Aids: Available in Large Print and Braille upon request and at no cost to the client
- Taglines: Must include DHCS tagline attachment explaining the availability of written translations or oral interpretation in all 17 statewide prevalent languages
- Printable: Must be provided to beneficiary within 5 business days, upon request

Informing Materials: Beneficiary Handbook

- AKA “Guide to Medi-Cal Services”

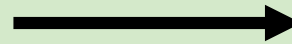
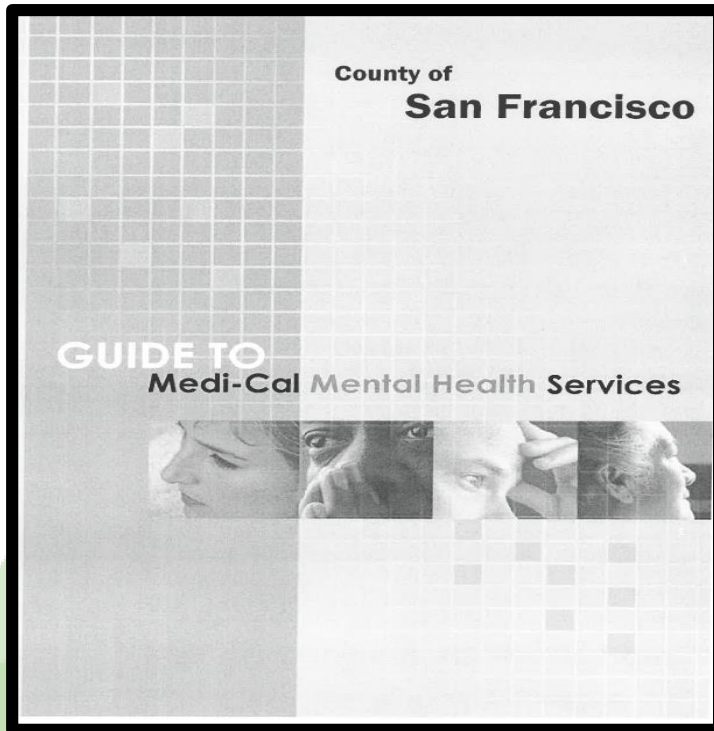


TABLE OF CONTENTS	
GENERAL INFORMATION.....	6
INFORMATION ABOUT THE MEDI-CAL PROGRAM	9
HOW TO TELL IF YOU OR SOMEONE YOU KNOW NEEDS HELP	1
ACCESSING SPECIALTY MENTAL HEALTH SERVICES.....	14
MEDICAL NECESSITY CRITERIA.....	17
SELECTING A PROVIDER.....	18
SCOPE OF SERVICES.....	20
ADVERSE BENEFIT DETERMINATIONS.....	25
PROBLEM RESOLUTION PROCESSES	29
THE GRIEVANCE PROCESS	30
THE APPEAL PROCESS (STANDARD AND EXPEDITED).....	31
THE STATE HEARING PROCESS.....	35
ADVANCE DIRECTIVE.....	38
BENEFICIARY RIGHTS AND RESPONSIBILITIES.....	39

DRAFT

Informing Materials: Provider Directory

- Existing Elements:

- Organizational provider's name

- Street Address

- Telephone number(s)

- Specialty (e.g., LGBTQ, Veterans, Homeless, etc.)

- Whether org provider is accepting new clients

Informing Materials: Provider Directory

- Existing Elements:

- Org provider's cultural and linguistic capabilities
- Whether org provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment
- Updated as needed, when BHS receives updated org provider information
- Posted on BHS website

Informing Materials: Provider Directory

- New Elements:

- Individual** provider's name (Licensed, Registered, Waivered, or Certified)

- Organizational provider Affiliation, Street Address, Telephone number(s), **Website**

- Individual** Provider's Specialty (e.g., LGBTQ)

- Whether **individual** provider is accepting new clients

Informing Materials: Provider Directory

- New Elements:

- Individual** provider's cultural and linguistic capabilities
- Whether individual provider has completed cultural competence training**
- Whether **individual** provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment
- Must be **updated at least monthly**, made available on BHS website **in a machine readable file and format**

Informing Materials: Drug Formulary

- The MHP/DMC-ODS contract does not include medication benefit for Medi-Cal clients
- The MCO contract includes medication benefits for some medications
 - San Francisco Health Plan (<https://www.sfhp.org/providers/pharmacy-services/sfhp-formular>)
 - Anthem BlueCross (<https://client.formularynavigator.com/Search.aspx?siteCode=1227528522>)
- Some medications paid through direct fee-for-service via DHCS

Informing Materials: Grievance/Appeal/NOABDs

- Grievance and Appeal Forms and Posters
- All Notices of Adverse Benefit Determination (previously referred to Notices of Action or NOAs)



Informing Materials: BHS Website

- All beneficiary informing materials must be posted on BHS website in all county threshold languages and large print
- BHS web format must meet modern accessibility standards to provide comparable access to those with physical, sensory, and/or cognitive disabilities

Network Adequacy Background

- Federal Network Adequacy Rules passed 2016
- State Assembly Bill 205 implemented specific provisions of the final rule, including network adequacy
 - **Changed** county categorization to be based on population density rather than population size
 - **Authorized** alternative access standards 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

Network Adequacy Background

- **Network Adequacy Standards apply to:**
 - Psychiatry
 - Outpatient Mental Health Services
 - Outpatient SUD Services (Non-OTP)
 - Opioid Treatment Programs (OTP)

Network Adequacy → Adequate Access to Appropriate Service Providers

- **Network Adequacy includes the following:**

- Availability of Services
- Assurances of Capacity
- Travel Time and Distance Standards
- Timely Access to Appointment Standards
- Alternative Access (community-based; mobile)

Network Adequacy → Adequate Access to Appropriate Service Providers

• **Network Adequacy includes (continued)**

- Provider/Service Capacity
- American Indian Health
- Language Accessibility
- Physical Accessibility

Network Adequacy Standards

Provider Type	<u>Timely Access Standards:</u> <i>From Request to Appointment</i>	<u>Travel Time/Distance Standards</u>
Psychiatry	Within 15 business days	15 miles or 30 minutes
OP Mental Health	Within 10 business days	15 miles or 30 minutes
OP SUD (non-OTPs)	Within 10 business days	15 miles or 30 minutes
Opioid Treatment Programs (OTPs)	Within 3 business days	15 miles or 30 minutes

Appointment time exceptions: Appointment time standards may be extended if the referring or treating provider, or the health professional providing triage or screening services, acting within their scope of practice and consistent with professionally recognized standards of practice, 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 (Cal. Code of Regs., tit.28, 1300.67.2.2(c)(5)(G))

Network Adequacy

Submit Network Adequacy Certification Tool to DHCS
(Quarterly for MH, Annually for DMC-ODS)

Demonstrate travel time and distance standards are met by
producing geo-maps of client residences and program
locations, by level of care and age group (8 maps)

**To
demonstrate
network
adequacy,
BHS must:**

Ensure new timely access to appointment standards are met
(outpatient, including psychiatry)

Provide data on language line/interpretation service usage, by
language

Update all policies with new network adequacy requirements

Report to DHCS whenever changes to network occur

How does this affect YOU (our Providers)?

- **We may need information about your agency/providers for “Network Adequacy Certification Tool”—for example:**
 - Level of staff proficiency in non-English languages;
 - Number of hours each staff member is available to serve Medi-Cal clients each week;
 - Maximum caseload for each staff member;
 - Number of hours of cultural competence training completed by each staff member in past year
 - Whether program facility is ADA certified

How does this affect YOU (our Providers)?

- **“Network Adequacy Certification Tool” (continued)**
 - BHS has provided DHCS with approximations using reasonable formulas
 - Based on DHCS’ response, BHS may need more specific information
 - If needed, BHS would send you a Survey Monkey link to obtain the needed information about your agency/providers.

How does this affect YOU (our Providers)?

- Referrals to Psychiatry: We need to measure time from Referral to Psychiatry to Receipt of Psychiatry Service. This may require creating a Psychiatry Referral Form that is completed by staff whenever referring to a psychiatrist.
- When Staff Leave: Notify BHS when a provider leaves if it affects Network Adequacy (e.g., a psychiatrist, a staff person with language capabilities otherwise not represented, etc.).
- Interpretation Services: Track number of service encounters requiring language line or other interpretation service, by each language used.

How does this affect YOU (our Providers)?

- Network Adequacy and other Final Rule changes may need to be reflected in your contract (possibly in the Exhibit A) and/or in the Declaration of Compliance.
- DHCS is reviewing our contract boilerplate and a sample of contractor Exhibit As to determine if changes will be required.

BHS Grievance & Appeal Policy

- **What you need to know**

- New policy combines the current grievance and appeal policies into one.
- DMC-ODS beneficiaries have access to the appeal and State hearing processes

BHS Grievance & Appeal Policy

- **What you need to know (continued)**

- New resolution timeframes:

Type	New Timeframe	Old Timeframe
Grievance	90 Calendar Days	60 Calendar Days
Expedited Appeal	72 Hours	3 Working Days
Standard Appeal	30 Calendar Days	45 Calendar Days

- Revised documents for grievance and appeals
- New policy will be posted, distributed and presented

BHS Grievance & Appeal Policy

• Important Reminders

- No retaliation
- Provide assistance upon client request
- Grievance and appeal documents be readily available
- Inform clients re: Grievance and Appeal process and document
- Respond in a timely manner to Grievance/Appeal Office
- An appeal is not a grievance

Notice of Adverse Benefit Determination Policy

- **What you need to know**

- Notice of Adverse Benefit Determination (NOABD) replaces the Notice of Action (NOA)
- DMC-ODS programs are required to issue NOABD
- Types of notices have been revised and expanded from 5 to 9—completed in a fillable pdf only
- Three (3) required enclosures: NOABD Your Rights, Language Assistance Taglines, and Nondiscrimination Notice.
- New policy will be posted, distributed, and presented

Notice of Adverse Benefit Determination Policy

- **Adverse benefit determination means any of the following:**
 - Denial or limited authorization of a requested service based on type or level of service, medical necessity, or effectiveness
 - Reduction, suspension, or termination of a previously authorized service
 - Denial of payment for a service, in whole or in part

Notice of Adverse Benefit Determination Policy

- **Adverse benefit determination means any of the following:**
 - Failure to provide services in a timely manner
 - Failure to resolve grievances or appeals within required timeframes
 - Denial of a beneficiary's request to dispute a financial liability

Notice of Adverse Benefit Determination Policy

• Reminders

- NOABD applies only to Medi-Cal beneficiaries' SMHS or DMC-ODS services
- BHS providers must issue NOABD (with required enclosures) for any action defined as an *adverse benefit determination*
- Time sensitive!

Notice of Adverse Benefit Determination Policy

• Reminders (continued)

- Beneficiary can request second opinion if service denial is due to not meeting *medical necessity* criteria and/or to continue current services if an appeal has been requested
- Document rationale for issuing NOABD in client's medical record
- Provide copy to BHS Quality Management

Compliance Program

- **What is a compliance program?**

- Basic Level:

- Prevention, Detection, Collaboration, Enforcement
- Policies, Procedures, Process developed to assure compliance with and conformity to federal and state law

- An Effective Compliance Program:

- On going process
- A part of a fabric of your organization
- Commitment to an ethical way of conducting business
- Value base system for doing the right thing

Credentialing

- **Purpose**

- Statewide uniform provider credentialing and re-credentialing requirement (CFR42, 438.214 and 438.602(b); Social Security Act section 1902(kk))

- **Background**

- MHP and DMC – ODS Waiver are considered Prepaid Inpatient Health Plan must therefore comply with federal managed care requirements.
- Credentialing/Recredentialing is one component.
- Process includes practitioners registration, certification, licensure, and/or professional association membership

Credentialing

- **Requirements**

- Ensures that each provider is qualified in accordance with current legal and professional standards.

- Good standing with Medicare/Medicaid

- Credentialing/Recredentialing requirements apply to all licensed, waived or registered MH providers and licensed, registered or certified alcohol or other drug counselors.

- **Credentialing/Recredentialing Policy**

- Verifying and Documenting

Credentialing

- **Credentialing/Recredentialing Policy**

- **Verifying and Documenting:**

- License and/or Board Certification or Registration.
- Evidence of graduation or completion of required education
- Proof of completion of relevant medical residency and/or specialty training.
- Continuing education requirements.
- Work History.
- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- Current Drug Enforcement Administration identification number.
- National Provider Identification

Credentialing

- **Credentialing/Recredentialing Policy (continued)**

- **Verifying and Documenting:**

- Malpractice Insurance.

- History of liability claims

- History of exclusion, termination or suspension.

- History of sanctions or limitations on license issued by any state agency or licensing boards.

Credentialing

- **Attestation**

- Sign and date written attestation verifying:
 - Limitations/inabilities that affect the providers performance
 - History of loss of license or felony conviction
 - History of loss or limitation of privileges or disciplinary activity
 - Lack of present illegal drug use.
 - Credentialing application accuracy and completeness

- **Recredentialing**

- To be done at a minimum every 3 years

Conflict of Interest Safeguards

- Involves any circumstance where an employee has a personal or financial interest that may improperly influence performance of SFDPH duties.
- Actual or perceived conflicts of interest arise from many different kinds of relationships.
- Cannot accept offers, gifts, favors, or other improper invitations in exchange for influence or assistance.
- Modest, non-cash gifts worth \$25 or less are acceptable.

Disclosure of Information

- In accordance with 42 C.F.R., section 455.104, Medicaid managed care entities must disclose certain information related to persons who have an ownership or controlling interest of 5% or more
- Criminal background checks pursuant to 42 C.F.R., section 455.434(a).

Prohibited / Excluded Affiliations

- **Penalties for Hiring or Doing Business with an Excluded Individual or Entity**
 - Civil fines and monetary penalties can include:
 - \$10,000 per item claimed or services provided
 - Possible program exclusion of the healthcare organization
 - Loss of right to bill CMS for services rendered
 - Possible fines for filing false claims
 - Possible criminal fines and/or jail time

Fraud Waste & Abuse

- **Definitions:**

- Fraud:

- Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

- Waste:

- Intentional or unintentional over-utilization of services, careless or thoughtless expenditure, consumption, mismanagement, squandering of government resource; or engaging in practices that result in unnecessary costs.

- Abuse:

- Any practice that is inconsistent with medical or business practice that results in an unnecessary cost to Medicare or Medicaid program, or in reimbursement for services that are not necessary or that fail to meet professionally recognized standards for health care.

Quality Elements

- Quality Assessment/Performance Improvement Program
- External Quality Review (EQR)
- Quality Strategy Report
- Quality Rating System

Record Keeping and Inspection

- 438.3(h) Inspection and audit of records and access to facilities.
 - ☐ “All contracts must provide CMS, DHCS, OIG, etc. or their designees access to inspect and audit any records or documents at any time...inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.”
- 438.3(u) Recordkeeping requirements.
 - ☐ “Must retain specified records for no less than 10 years.”

Summary & Recap

- **Point #1: Standardized Benefits, Standardized Regulations**
 - “Purchasers” of health care services need to be able to oversee services, dollars and outcomes
 - In theory, final rule “levels the playing field” across Medicaid managed care plans
 - Improved consumer protections are a “win” for Medical beneficiaries

Summary & Recap

• Point #2: Ongoing Implementation

- BHS is waiting for feedback from DHCS—we know this is an ongoing implementation process!
- Network Adequacy and other Final Rule changes may need to be reflected in your contract (possibly in the Exhibit A) and/or in the Declaration of Compliance.
- DHCS is reviewing our contract boilerplate and a sample of contractor Exhibit As to determine if changes will be required.

Summary & Recap

- **Point #3: Planning & Implementing**
 - Make sure you are using the most current documents, forms and policies that are issued by BHS
 - Maximize communication with BHS as you begin to think about implementation.

Final Rule Resources

• Federal-Level:

- Federal Register MMFR: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>
- Medicaid.Gov MMCFR: <https://www.medicare.gov/medicare/managed-care/guidance/final-rule/index.html>

• State-Level:

- DHCS MMCFR webpage: <http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx>
- DHCS Mental Health Plan Boilerplate Contract: http://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf

• Others:

- Kaiser Family Foundation summary: <https://www.kff.org/medicare/issue-brief/cmss-final-rule-on-medicare-managed-care-a-summary-of-major-provisions/>
- Families USA Network Adequacy Standards: <http://familiesusa.org/product/medicare-managed-care-rule-network-adequacy-standards>