Medicaid Managed Care Final Rule Implementation & Quality Management in Santa Clara County Behavioral Health Services

January 30, 2018

SANTA CLARA COUNTY
Behavioral Health Services

At the intersection of health care policy, politics and communications.
Presentation Overview

- Regulatory Landscape & Context
- Overview of the Medicaid Managed Care Final Rule
  - Purpose & Goals
  - Summary of Key Provisions
- Final Rule Implications for BHSD Providers
  - Examples
  - Questions & Discussion
- Impact of the Final Rule on BHSD Quality Management Efforts and Responsibilities
- Resources
Key Terms

**BHSD**: Santa Clara County Behavioral Health Services Department

**CMS**: Centers for Medicare and Medicaid Services

**DHCS**: California State Department of Health Care Services

**DMC-ODS**: Drug Medi-Cal Organized Delivery System

**EQRO**: External Quality Review Organization

**FFS**: Fee for Service

**MHP**: Mental Health Plan

**NOABD**: Notice of Adverse Benefit Determination (a.k.a. “NOA”)

**PIP**: Performance Improvement Project

**PIHP**: Pre-Paid Inpatient Health Plan

**QAPI**: Quality Assessment and Performance Improvement

**QI**: Quality Improvement

**QIC**: Quality Improvement Committee

**QRS**: Quality Rating System
Regulatory Landscape & Context
Regulatory Landscape: Governing Authorities

MHP Contract / ODS Intergovernmental Agreement
Reflect current responsibilities and authorities based on federal and state law. Updated to reflect substantive changes in either, such as new federal managed care requirement (i.e. Final Rule).

Waiver Provisions
Subject to change every 2-5 years based on negotiated renewal terms between CMS and DHCS.

Triennial Review Protocol
Published / updated annually.

State Law (WIC)
Subject to change annually based on legislative action.

State Regulations (e.g. Title 9)
Updated infrequently. Often in conflict with (superseded by) state and federal law.
1915(b) SMHS Waiver Special Terms and Conditions (STCs)

1115 DMC-ODS Waiver Special Terms and Conditions (STCs)

Contracts / Intergovernmental Agreements*

External Quality Review Organization

Triennial Protocol

*The MHP contract language is currently being revised to ensure compliance with the Medicaid Managed Care Final Rule.
Managed Care Context

- **PIHPs:** Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots are considered to be prepaid inpatient health plans (PIHPs) under the authority of California’s waivers. A PIHP is an entity that:
  - Provides services to beneficiaries under contract with the state and on the basis of capitation payments or other payment arrangements that do not use State plan payment rates;
  - Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and
  - Does not have a comprehensive risk contract.

- **Responsibility:** Counties provide or arrange for Medi-Cal specialty mental health services (SMHS) and SUD services for beneficiaries in their county that meet specified medical necessity criteria. Beneficiary freedom of choice for plan enrollment has been waived for the covered MH and SUD services.

- **Managed Care Requirements:** As PIHPs, MHPs and DMC-ODS pilots are subject to federal managed care regulations related to beneficiary rights and protections, quality improvement and review, and adequacy and availability of services (among others).
**Beneficiary Services: Mental Health**

- **County MHPs**: Responsible for authorization and payment of a full continuum of SMHS, including inpatient post-stabilization services, rehabilitative services, and targeted case management for beneficiaries meeting medical necessity criteria.

- **Services**:
  - Psychiatric Inpatient Hospital Services.
  - Rehabilitative Mental Health Services.
  - Targeted Case Management.
  - EPSDT.
Beneficiary Services: Substance Use Disorders

**Standard DMC Program:**
- Outpatient Drug Free Treatment
- Intensive Outpatient Treatment
- Naltrexone Treatment
- Narcotic Treatment Program
- Perinatal Residential SUD Services (limited by IMD exclusion)
- Detoxification in a Hospital (with a TAR)

**DMC-ODS Pilot Program:**
- Outpatient Services
- Intensive Outpatient Services
- Naltrexone Treatment
- Narcotic Treatment Program
- Residential Services (not restricted by IMD exclusion or limited to perinatal)
- Withdrawal Management (at least one ASAM level)
- Recovery Services
- Case Management
- Physician Consultation
- Partial Hospitalization (Optional)
- Additional Medication Assisted Treatment (Optional)
Medicaid Managed Care Final Rule
Overview

• Federal Managed Care Regulations – Part 438 of Title 42 Code of Federal Regulations.

• Effective date of Final Rule was July 5, 2016, with phased implementation over a 3 year period.

• Applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), and Pre-paid Ambulatory Health Plans (PAHPs).

• New Final Rule provisions will be integrated into the SCC contract boilerplate for providers, and policies and procedures will also be revised to reflect the new guidelines.
Purpose & Goals of the Final Rule

To support State efforts to advance delivery system reform and improve the quality of care.

To strengthen the beneficiary experience of care and key beneficiary protections.

To strengthen program integrity by improving accountability and transparency.

To align key Medicaid and CHIP managed care requirements with other health coverage programs.
Overview of 42 CFR Part 438

- **Subpart A** – General Provisions
- **Subpart B** – State Responsibilities
- **Subpart C** – Enrollee Rights & Protections
- **Subpart D** – MCO, PIHP, and PAHP Standards
- **Subpart E** – Quality Measurement & Improvement + External Quality Review
- **Subpart F** – Grievance & Appeal System
- **Subpart G** – Reserved
- **Subpart H** – Additional Program Integrity Safeguards
- **Subpart I** – Sanctions
- **Subpart J** – Conditions for Federal Financial Participation
- **Subpart K** – Parity in Mental Health & Substance Use Disorder Benefits
Key Provisions Effective July 5, 2016

- §438.2 – Definitions
- §438.3(a) – CMS Review & Approval of Contracts
- §438.3(d) – Enrollment Discrimination Prohibition
- §438.3(f) – Compliance with Applicable Laws & Conflict of Interest Safeguards
- §438.3(j) – Advance Directives
- §438.3(k) - Subcontracts
- §438.3(l) – Choice of Network Provider
- §438.100 – Enrollee Rights
- §438.102 – Provider-Enrollee Communications
- §440.262 – Access & Cultural Considerations
- §438.610 – Prohibited Affiliations
Key Provisions Effective July 1, 2017

- §438.3(h) – Inspection & Audit of Records & Access to Facilities
- §438.10 – Information Requirements
- §438.66 – State Monitoring Requirements
- §438.208 – Coordination & Continuity of Care
- §438.210 – Coverage and Authorization
- §438.230 – Subcontractual Relationships & Delegation
- §438.242 – Health Information Systems
- §438.330 – Quality Assessment & Performance Improvement
- Subpart F – Grievance & Appeal System
- Subpart H – Additional Program Integrity Safeguards
- Subpart K – Parity in Mental Health & Substance Use Disorder Benefits (October 2, 2017)
Key Provisions Effective July 1, 2018

• §438.62 – Continued Services to Enrollees
• §438.68 – Network Adequacy
• §438.206 – Availability of Services
• §438.207 – Assurances of Adequate Capacity
• §438.71 – Beneficiary Support System
• §438.602(b) & §438.608(b) – Screening & Enrollment
• §438.340 – Quality Strategy
• §438.350-364 – EQR Requirements
• §438.818 – Encounter Data
Key Provisions Effective After 2018

- §438.66(e) – Annual Program Assessment Reports
- §438.358 – Activities Related to EQR
- §438.334 – Quality Rating System
Medicaid Managed Care Final Rule
 Definitions & Contract Requirements
Key Definitions [§438.2]

- **Network Provider** means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and received Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state’s contract with a MCO, PIHP or PAHP.

- **Subcontractor** means an individual or entity that has a contract with an MCO, PIHP, PAHP or PCCM entity that relates directly or indirectly to the performance of the MCOs, PIHPs, PAHPs, or PCCM entity’s obligations under its contract with the State.
Enrollment Discrimination Prohibited [§438.3(d)]

• Prohibits discrimination against individuals on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

• Prohibits the use of any policy or practice which has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.
Choice of Provider [§438.3(l)]

- Each beneficiary must be allowed to choose his or her network provider to the extent possible and appropriate.
Continued Services [§438.62]

• The State agency must arrange for Medicaid services to be provided without delay to any Medicaid beneficiary.

• The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to Plan or transition from one Plan to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Audit & Inspection Rights [§438.3(h)]

- All contracts must provide that the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Plan, or its subcontractors, and may, 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.
Provider Selection and Contracting Requirements
Provider Selection [§438.214]

- Credentialing & Re-Credentialing
  - The State must establish a uniform credentialing and re-credentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each Plan to follow those policies.
  - Each Plan must follow a documented process for credentialing and re-credentialing of network providers.

- Nondiscrimination
  - The Plan’s network selection policies and procedures, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

- Excluded Providers
  - The Plan may not employ or contract with providers excluded from participation in Federal health care programs.

- State Requirements
  - The Plan must comply with any additional requirements established by the State.
Prohibited Affiliations [§438.610]

- A Plan may not knowingly have a relationship with the following:
  - An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
  - An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101.
  - Individual or entity that is excluded from participation in any Federal health care program.

- Prohibited relationships:
  - A director, officer, or partner of the Plan.
  - A subcontractor of the Plan, as governed by §438.230 (sub contractual relationships & delegation).
  - A person with beneficial ownership of 5 percent or more.
  - A network provider or person with an employment, consulting or other arrangement with the Plan for the provision of items and services that are significant and material to the Plan’s obligations under its contract with the State.
Prohibited Affiliations (cont.)

- If the State finds that a Plan is not in compliance, the State:
  - Must notify the Secretary of the noncompliance.
  - May continue an existing agreement with the Plan unless the Secretary directs otherwise.
  - May not renew or otherwise extend the duration of an existing agreement with the Plan unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
Screening & Enrollment of Providers
[§438.602(b) & §438.608(b)]

• The State must screen and enroll, and periodically revalidate, all network providers of the Plan.
  • This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.

• The State must ensure that all network providers are enrolled with the State as Medicaid providers consistent with provider disclosure, screening and enrollment requirements.

• This provision does not require the network provider to render services to FFS beneficiaries.
Subcontractual Relationships [§438.230]

• If any of the Plan’s activities or obligations under its contract with the State are delegated to a subcontractor…
  • The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
  • The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Plan’s contract obligations.
  • The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the Plan determine that the subcontractor has not performed satisfactorily.
Subcontractual Relationships (cont.)

• The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.

• The subcontractor agrees that:
  • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor’s contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Plan’s contract with the State.
  • The subcontractor will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
  • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
  • If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
Network Adequacy & Timeliness Standards
Network Adequacy Requirements [§438.68]

- Required the State to develop and enforce network adequacy standards – Codified in A.B. 205.

- Required the State to develop time & distance standards for behavioral health providers (both adult & pediatric).

- 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.
## Network Adequacy Standards for Santa Clara County

<table>
<thead>
<tr>
<th>Service</th>
<th>Timely Access Standards (from request to appointment)</th>
<th>Time &amp; Distance Standards (from beneficiary’s place of residence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient MH Services</td>
<td>Within 10 business days</td>
<td>15 miles or 30 minutes</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Within 15 business days</td>
<td>15 miles or 30 minutes</td>
</tr>
<tr>
<td>Outpatient SUD Services</td>
<td>Within 10 business days</td>
<td>15 miles or 30 minutes</td>
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<tr>
<td>Opioid Treatment Programs</td>
<td>Within 3 business days</td>
<td>15 miles or 30 minutes</td>
</tr>
<tr>
<td>Hospital</td>
<td>N/A</td>
<td>15 miles or 30 minutes</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>N/A</td>
<td>10 miles or 30 minutes</td>
</tr>
</tbody>
</table>
Availability of Services [§438.206]

• Each State must ensure that all services covered under the State plan are available and accessible to beneficiaries of the Plan in a timely manner.

• The State must also ensure that provider networks for services covered under the contract meet the standards developed by the State.
Assurances [§438.207]

- The State must ensure that each Plan gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State’s standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1).

- Documentation must be submitted annually or whenever there is a significant change in operations that would affect the adequacy of capacity and services.
Coverage & Authorization of Services
Coverage & Authorization [§438.210]

• **Coverage:** Each contract between the State and Plan must:
  - Identify, define, and specify the amount, duration, and scope of each service that the Plan is required to offer.
  - Require that the services be furnished in an amount, duration, and scope that is no less than that furnished to beneficiaries under FFS Medicaid.
  - Provide that the Plan:
    - Ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
    - May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
Coverage & Authorization (cont.)

• Permit a Plan to place appropriate limits on a service...
  - On the basis of criteria applied under the State plan, such as medical necessity; or
  - For the purpose of utilization control.

• Specify what constitutes “medically necessary services” in a manner that...
  - Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
  - Addresses the extent to which the Plan is responsible for covering services.
Coverage & Authorization (cont.)

- **Authorization of services.** For the processing of requests for initial and continuing authorizations of services, each contract must require that the Plan:
  - Ensure its subcontractors have in place, and follow, written policies and procedures.
  - Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
  - Consult with the requesting provider for medical services when appropriate.
  - That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the beneficiary’s medical, behavioral health, or long-term services and supports needs.
Notice of Adverse Benefit Determination [§438.210(c)]

• Also known as a “Notice of Action.”

• Each contract must provide for the Plan to notify the requesting provider, and give the beneficiary written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

• For Plans, the beneficiary’s notice must meet the requirements of §438.404.
Information Requirements
Information Requirements [§438.10]

• Provide all required information in this section to beneficiaries in a manner and format that may be easily understood and is readily accessible.

• The State must utilize its beneficiary support system to provide information.

• The State must operate a website that provides the content, directly or by linking to the Plan’s website, regarding:
  • Beneficiary Handbook.
  • Provider Directory.
  • Formulary.

• For consistency in the information provided, the State must develop and require each Plan to use:
  • Definitions for managed care terminology; and,
  • Model handbooks and notices.
Information Requirements (cont.)

• The State must ensure that each Plan provides the required information to beneficiaries.

• May be provided electronically if all of the following are met:
  • The format is readily accessible by compliance with modern accessibility standards (508 guidelines, Section 504, and W3Cs Web Content Accessibility Guidelines).
  • The information is on the State or Plan’s website in a way that is prominent and readily accessible.
  • The information must be retained and printable.
  • Documents must be available for print upon request and request must be fulfilled within 5 business days.

• Each Plan must have in place mechanisms to help beneficiaries understand the requirements and benefits of the Plan.
Language & Format [§438.10(d)]

• DHCS must have a methodology for determining written threshold languages.

• Oral interpretation must be available, free of charge, in all languages not just threshold languages.

• All written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation.

• Large print means printed in a font size no smaller than 18 point.
Each Plan must make its written materials that are critical to obtaining services available in the prevalent non-English languages [in the county], including at a minimum:

- Provider Directories.
- Handbooks.
- Appeal and Grievance Notices.
- Denial and Termination Notices.

Alternate formats (i.e. Braille or Audio) and Auxiliary Aids (i.e. TTY/TDY and American Sign Language) must be made available upon request at no cost.
Information Content [§438.10(e)]

- Within specified timeframes, Plans must provide beneficiaries the following information:
  - Basic features of managed care.
  - Covered benefits & service area.
  - Provider directory and formulary information.
  - Any cost-sharing imposed by the MHP.
  - Adequate access to covered services, including the network adequacy standards.
  - Responsibility for coordination of beneficiary care.
  - Quality and performance indicators for MHPs, including beneficiary satisfaction.
Each Plan must provide each beneficiary with a beneficiary handbook.

The content of the handbook must include:
- Benefits provided by the Plan.
- How and where to access benefits, including cost-sharing and transportation.
- The amount, duration and scope of benefits available under the contract in sufficient detail to ensure beneficiaries understand the benefits to which they are entitled.
- Procedures for obtaining benefits, including any requirements for services authorizations and/or referrals.
- The extent to which, and how, after-hours and emergency coverage are provided.
- The extent to which, and how, enrollees may obtain benefits from out-of-network providers.
Beneficiary Handbook (cont.)

- The content of the handbook must include:
  - Cost sharing, if any is imposed.
  - Beneficiary rights and responsibilities.
  - The process of selecting and changing the beneficiary’s provider.
  - Grievance, appeal and fair hearing procedures and timeframes.
  - How to exercise an advance directive.
  - How to access auxiliary aids and services, including additional information in alternative formats or languages.
  - The toll-free telephone number for member services.
  - Information on how to report suspected fraud or abuse.
  - Any other content required by the State.
Provider Directory [§438.10(h)]

• The Plan must make available in paper form upon request and electronic form, the following information about its network providers:
  • The provider’s name as well as any group affiliation.
  • Street address(es).
  • Telephone number(s).
  • Website, URL, as appropriate.
  • Specialty, as appropriate.
  • Whether the provider will accept new beneficiaries.
  • The provider’s cultural and linguistic capabilities.
  • Whether the provider’s office/ facility has accommodations for people with physical disabilities.

• Information in a paper provider directory must be updated at least monthly and the electronic provider directories must be updated no later than 30 calendar days after the Plan receives updated provider information.

• Must be made available on the Plan’s website in a machine readable file and format.
Provider – Beneficiary Communications [§438.102]

- A Plan may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient, for the following:
  - The beneficiary’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the beneficiary needs to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The beneficiary’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
Grievance & Appeal Systems
Grievance & Appeal Systems [§438.228]

• The State must have a grievance and appeal system that meets the requirements of Subpart F.

• If the State delegates to the Plan responsibility for Notice of Action, the State must conduct random reviews of the Plan and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.
Key Definition [§438.400(b)]

- **Adverse benefit determination** means any of the following:
  - The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
  - The reduction, suspension, or termination of a previously authorized service.
  - The denial, in whole or in part, of payment for a service.
  - The failure to provide services in a timely manner, as defined by the State.
  - The failure of a Plan to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
  - For a resident of a rural area with only one MCO, the denial of a beneficiary’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
  - The denial of a beneficiary’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities.
General Requirements [§438.402]

- Plans must have a grievance and appeal system in place for beneficiaries.
- Plans may have only one level of appeal for beneficiaries.
- A beneficiary may file a grievance and request an appeal.
- A beneficiary may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.
- In the case of a Plan that fails to adhere to the notice and timing requirements in §438.408, the beneficiary is deemed to have exhausted the Plan’s appeals process and the beneficiary may initiate a State fair hearing.
- The State may offer and arrange for an external medical review.
- With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of a beneficiary.
Timing & Procedures [§438.402]

• A beneficiary may file a grievance with the Plan at any time.

• The beneficiary may file a grievance either orally or in writing and, as determined by the State, either with the State or with the Plan.

• Following receipt of a notification of an adverse benefit determination by a Plan, a beneficiary has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

• The beneficiary may request an appeal either orally or in writing. Further, unless the beneficiary requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.
Contents of a NOABD [§438.404]

• The adverse benefit determination the Plan has made/intends to make and the reasons for the determination.

• The beneficiary’s right to be provided with copies of all information relevant their determination, including medical necessity criteria, and processes, strategies, or standards used to set coverage limits.

• The beneficiary’s right to request an appeal of the Plan’s determination, including information on exhausting the Plan’s one level of appeal and the right to request a State fair hearing.

• The procedures for exercising the rights outlined in the notice.

• The circumstances under which an appeal process can be expedited and how to request it.

• The beneficiary’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, under which the beneficiary may be required to pay the costs of these services.
Handling of Grievance & Appeals [§438.406]

• In handling grievances and appeals, each Plan must give a beneficiary any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal.

• This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
Handling of Grievances & Appeals (cont.)

• A Plan’s process for handling beneficiary grievances and appeals of adverse benefit determinations must:
  • Acknowledge receipt of each grievance and appeal.
  • Ensure that the individuals who make decisions on grievances and appeals are individuals have clinical expertise, consider all submitted information, and are free from prior involvement in the grievance.

• Provide that oral inquiries seeking to appeal a determination are treated as appeals and must be confirmed in writing, unless an expedited resolution is requested.

• Provide the beneficiary a reasonable opportunity to present evidence and testimony and make legal and factual arguments.

• Inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals.

• Provide the beneficiary and representative, free of charge, and in advance of the timeframe, the beneficiary’s case file, including records and documents considered in connection with the appeal of the determination.

• Include, as parties to the appeal, the beneficiary and his or her representative, or the legal representative of a deceased beneficiary’s estate.
Resolution & Notification [§438.408]

- Each Plan must resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary’s health condition requires, within timeframes:
  - For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the Plan receives the grievance.
  - For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the Plan receives the appeal.
  - For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the Plan receives the appeal.
Recordkeeping [§438.416]

• The State requires Plans to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

• The record of each grievance or appeal must contain, at a minimum, all of the following information:
  • A general description of the reason for the appeal or grievance.
  • The date received.
  • The date of each review or, if applicable, review meeting.
  • Resolution at each level of the appeal or grievance, if applicable.
  • Date of resolution at each level, if applicable.
  • Name of the covered person for whom the appeal or grievance was filed.

• The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.
Effectuation of Reversals [§438.424]

• If the Plan or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Plan must authorize or provide the disputed services promptly and as expeditiously as the beneficiary’s health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

• If the Plan or the State fair hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the Plan must pay for those services, in accordance with State policy and regulations.
Program Integrity
State Responsibilities [§438.602]

- **Ownership and control information**
  - The State must review the ownership and control disclosures submitted by the Plan, and any subcontractors as required in §438.608(c).

- **Periodic audits**
  - The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Plan.

- **Transparency**
  - The State must post on its website, as required in §438.10(c)(3), the following documents and reports:
    - Plan contract(s).
    - Network adequacy data.
    - Information on ownership and control.
    - The results of periodic financial and encounter data audits.
Program Integrity [§438.608]

- The State, through its contract with the plan must:
  - Ensure that all network providers are enrolled with the State as Medicaid providers.
  - Require that the Plan, or subcontractor, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
Fraud, Waste, & Abuse [§438.608]

- To detect and prevent fraud, waste, and abuse, the Plan must:
  - Maintain a compliance program.
  - Ensure prompt reporting to the State of all overpayments, specifying the overpayments due to potential fraud.
  - Ensure prompt notification to the State when it receives information about changes in an beneficiary’s circumstances that may affect the beneficiary’s eligibility.
  - Notify the State when it receives information about a change in a network provider’s circumstances that may affect the network provider’s eligibility to participate in the managed care program, including the termination of the provider agreement with the Plan.
Fraud, Waste, & Abuse (cont.)

• To detect and prevent fraud, waste, and abuse, the Plan must (cont.):
  • Ensure a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.
  • Ensure prompt notification of any potential fraud, waste, or abuse to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
  • Ensure suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with §455.23 of this chapter.
Disclosures [§438.608]

The State must ensure, through its contracts, that each Plan and any subcontractors:

- Provides written disclosure of any prohibited affiliation under §438.610.
- Provides written disclosures of information on ownership and control required under §455.104 of this chapter.
- Reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.
Overpayment Recoveries [§438.608]

- Contracts with the Plan must specify the following:
  - The retention policies for the treatment of recoveries of all overpayments from the Plan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
  - The process, timeframes, and documentation required for reporting the recovery of all overpayments.
  - The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MHP is not permitted to retain some or all of the recoveries of overpayments.
Overpayment Recoveries (cont.)

• Each Plan needs to have a mechanism for a network provider to report when it has received an overpayment, to return the overpayment to the Plan within 60 calendar days after the overpayment was identified, and to notify the Plan in writing of the reason for the overpayment.

• Each Plan must report annually to the State on their recoveries of overpayments.
Monitoring & Quality
State Monitoring Requirements

[§438.66]

• The State must implement a monitoring system for all managed care programs.
• The State’s system must address all aspects of the managed care program, including the performance of each Plan in at least the following areas:
  • Administration and management.
  • Appeal and grievance systems.
  • Claims management.
  • Beneficiary materials and customer services, including the activities of the beneficiary support system.
  • Finance, including medical loss ratio reporting.
  • Information systems, including encounter data reporting.
  • Marketing.
  • Medical management, including utilization management and case management.
  • Program integrity.
  • Provider network management, including provider directory standards.
  • Availability and accessibility of services, including network adequacy standards.
  • Quality improvement.
  • Areas related to the delivery of LTSS.
  • All other provisions of the contract, as appropriate.
Use of Data to Improve Performance
[§438.66]

• The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:
  • Enrollment and disenrollment trends in each Plan.
  • Beneficiary grievance and appeal logs.
  • Provider complaint and appeal logs.
  • Findings from the State’s External Quality Review process.
  • Results from any beneficiary or provider satisfaction survey conducted by the State or Plan.
  • Performance on required quality measures.
  • Medical management committee reports and minutes.
  • The annual quality improvement plan for each Plan.
  • Audited financial and encounter data submitted by each Plan.
  • The medical loss ratio summary reports required by §438.8.
  • Customer service performance data submitted by each Plan and performance data submitted by the beneficiary support system.
Annual Program Assessment Reports
[§438.66]

- DHCS must submit an annual report to CMS covering, at a minimum, the following areas:
  - Financial performance of each Plan, including MLR experience.
  - Encounter data reporting by each Plan.
  - Enrollment and service area expansion (if applicable) of each Plan.
  - Modifications to, and implementation of, Plan benefits covered under the contract with the State.
  - Grievance, appeals, and State fair hearings for the managed care program.
  - Availability and accessibility of covered services within the Plan contracts, including network adequacy standards.
  - Evaluation of Plan performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.
  - Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted Plan to improve performance.
  - Activities and performance of the beneficiary support system.
Annual Program Assessment Reports (cont.)

- Additionally, the annual report must:
  - Be posted on the DHCS website.
  - Be provided to the DHCS Stakeholder Advisory Group.
  - Be submitted to CMS within 180 days of each contract year.
Accreditation [§438.332]

• DHCS must require that each Plan inform the State whether it has been accredited by a private independent accrediting entity.

• Each Plan that has received accreditation must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including:
  • Accreditation status, survey type, and level (as applicable).
  • Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.
  • Expiration date of the accreditation.

• DHCS must make the accreditation status for each contracted Plan available on the Web site required under §438.10(c)(3), including whether each Plan has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and, update this information at least annually.
External Quality Review Requirements [§438.350-370]

- New mandatory activity-validation of the Plan’s network adequacy during the preceding 12 months.
- New optional EQR-related activity to assist with the quality rating of Plans consistent with the Quality Rating System.
- CMS expects to issue protocols for the pre-existing mandatory and optional EQR activities in the Fall of 2017.
- CMS expects to issue the protocol for the new validation of network adequacy activity in a second round after the Fall of 2017.
Quality Rating System [§438.334]

- CMS, in consultation stakeholders and following a public comment period, will identify performance measures and a methodology for a Medicaid managed care quality rating system that aligns with the summary indicators of the qualified health plan quality rating system.

- States may submit a request to CMS for approval to use an alternative Medicaid managed care quality rating system.

- Each year, the State must collect data from each contracted MHP and issue an annual quality rating for each MHP using the Medicaid managed care quality rating system.

- DHCS must prominently display the quality rating given by to each MHP on the website.
Quality Rating Period

- No later than 3 Years from Date of Final Notice Published in Federal Register.
  - A public engagement process to develop a proposed QRS framework and methodology.
  - Similar to process used for Marketplace QRS including multiple state and stakeholder listening sessions and technical expert panel.
  - Publication of a proposed QRS in the Federal Register, with opportunity to comment, followed by notice of the final Medicaid and CHIP QRS expected in 2018.

- CMS expects to issue the protocol in time for states to begin implementing the QRS within the 3 year QRS compliance timeframe, including any states that wish to implement earlier in that 3 year timeframe.
Final Rule Implications for BHSD Providers
Implications for Providers

• BHSD is revising Policies and Procedures to reflect Final Rule requirements and their impact on providers. Revisions will impact the policies and procedures related to*:
  • Timely Access.
  • Utilization Management.
  • Clinical Quality.

• BHSD has begun the process of amending provider boilerplate contracts.
  • 1/12/18 – 2/12/18: Contract amendments to providers.
  • 2/5/18 – 2/27/18: Signed amendments returned to BHSD (dates align with Board of Supervisors meeting schedule).
  • 4/5/18: Deadline to execute contracts.

* Please note that this list is not comprehensive. The County will amend several other P&Ps to align with the Final Rule.
Example Implications for Providers

**Timely Access**

- Providers must have the **same hours of operation for Medi-Cal beneficiaries** as they do for non Medi-Cal beneficiaries and the **same hours of operation for BHSD covered services** as other Medi-Cal covered services.
- BHSD will establish **assessment and monitoring mechanisms** to ensure providers comply with timely access requirements.
- BHSD will ensure that providers **provide physical access, reasonable accommodations, culturally competent communications, and accessible equipment** for Medi-Cal beneficiaries with physical or mental disabilities.
- BHSD will ensure that providers adhere to state time and distance standards, which for Santa Clara County require that behavioral health services are provided within **15 miles or 30 minutes** from a beneficiary's residence.
- Providers must fully complete the **Timely Access Log** required fields for all clients seeking care.

**Utilization Management**

- BHSD will **disseminate practice guidelines** to all affected providers, share new or modified guidelines at QA workgroup meetings, and assure that decisions for utilization management are consistent with the guidelines.

**Clinical Quality**

- BHSD contract monitors will **provide training and technical assistance** to address gaps in the delivery of high quality, medically necessary care.
Monitoring Provider Compliance and Consequences for Non-compliance

**Monitoring:**
- The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to **audit, evaluate, and inspect** any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor’s contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Plan’s contract with the State. The right to audit exists 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

- If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

**Consequences**
- BHSD provider contracts must either provide for **revocation of the delegation of activities or obligations**, or specify other remedies in instances where the State or the Plan determine that the subcontractor has not performed satisfactorily.

- **Suspension of payments** to a network provider for which the State determines there is a credible allegation of fraud in accordance with §455.23 of this chapter.
Questions?
Impact of the Final Rule on BHSD Quality Management Efforts and Responsibilities
Quality Assessment & Performance Improvement Program Requirements [§438.330]

- Each Plan must implement an ongoing and comprehensive QAPI program for the services it furnishes to beneficiaries. Key provisions include:
  - Performance Improvement Projects (PIPs) specified by the state and, if applicable, CMS.
  - Collection and submission of performance measurement data to the state.
  - Mechanisms to detect under- and overutilization of services.
  - Assessment of the quality and appropriateness of care furnished to beneficiaries with special health care needs.
BHSD Improvements to the QAPI Program

• Integrated Behavioral Health Quality Improvement Committee (BHQIC).

• Development of **Performance Monitoring Unit**.

• Development of **Utilization Management Unit**.

• Development of **Clinical Standards Management Unit**.

• **Increased communication and data-sharing** between Pharmacy Services and Quality Management to inform quality improvement efforts.

• Creation of **Cultural Competency Coordinator** position.
BHQIC Structure & Next Steps

• In an effort to increase system integration and promote a client-centered approach to quality improvement, BHSD is implementing an integrated BHQIC in March 2018.

• Participation on the BHQIC is voluntary and by invitation of the BHSD.

• Invitations will be emailed out in February 2018 and the first meeting will be in March 2018.
MH & SUD Integration In Santa Clara County

Mental Health and Substance Use Disorder Division

County Mental Health Plans – Specialty Mental Health

County Alcohol and Drug Programs – Drug Medi-Cal (SUD Treatment)

BHSD Working Towards Integration  
2018- Integration of Quality Improvement Efforts
Resources

• DHCS Medicaid Managed Care Final Rule Webpage: http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx

• MHSUDS Information Notice Webpage: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

• CBHDA Medicaid Managed Care & Parity Regulations Resource Page: http://www.cbhda.org/member-info/committees/medical-policy/federal-regulations-resources/

• MHSDFinalRule@dhcs.ca.gov
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