Implementing the Medicaid Managed Care Final Rule

DHCS and County Perspectives on Putting the Rule into Action

August 7, 2017

Today's Presenters

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  Mental Health Services Division
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Presentation Outline

- Medicaid Managed Care (MMC) Final Rule Overview and CMS Goals
- DHCS Priorities for Implementation
- San Bernardino County: Developing and Executing a Final Rule Work Plan
- Butte County Perspectives
- Mariposa County Perspectives
- County Discussion
- Additional Resources

FINAL RULE OVERVIEW AND GOALS

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Medicaid Managed Care Final Rule Overview

- The Final Rule updates Part 438 of title 42 Code of Federal Regulations
  - Part 438 is cited throughout the MHP Contract
- Final regulations published in the Federal Register July 5, 2016
- Implementation varies by section through 2018 and beyond
  - Includes many provisions applicable to counties effective July 1, 2017

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CMS Goals for the Final Rule

1) Delivery system reform and improve quality of care
2) Strengthen beneficiary experience of care and beneficiary protections
3) Strengthen program integrity by improving accountability and transparency
4) Alignment of managed care requirements with other health coverage programs

DHCS PRIORITIES FOR IMPLEMENTATION

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Department of Health Care Services

Medicaid Managed Care Final Rule Priorities for Implementation

Autumn Boylan, MPH

Mental Health Services Division

42 C.F.R. Part 438 Overview

- Subpart A – General Provisions
- Subpart B – State Responsibilities
- Subpart C – Enrollee Rights and Protections
- Subpart D – MCO, PIHP and PAHP Standards
- Subpart E – Quality Measurement and Improvement; External Quality Review
- Subpart F – Grievance and 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 and Substance Use Disorder Benefits

Key Provisions Effective July 5, 2016

- §438.2 Definitions
- §438.3(a) CMS Review and Approval of Contracts
- §438.3(d) Enrollment Discrimination Prohibition
- §438.3(f) Compliance with Applicable Laws and 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 and Cultural Considerations
- §438.610 Prohibited Affiliations

Key Provisions Effective July 1, 2017

- §438.3(h) Inspection and Audit of Records and Access to Facilities
- §438.10 Information Requirements
- §438.66 State Monitoring Requirements
- §438.208 Coordination and Continuity of Care
- §438.210 Coverage & Authorization
- §438.230 Subcontractual Relationships and Delegation
- §438.242 Health Information Systems
- §438.330 Quality Assessment and Performance Improvement
- Subpart F - Grievance and Appeal System
- Subpart H – Additional Program Integrity Safeguards
- Subpart K – Parity in Mental Health and 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) and 438.608(b) Screening & Enrollment
- §438.340 Quality Strategy
- §§ 438.350-364 EQR Requirements
- §438.818 Encounter Data

Provisions Effective after 2018

- §438.66(e) Annual Program Assessment Reports
- §438.358 Activities Related to External Quality Review
- §438.334 Quality Rating System

Priorities for Implementation

Citation	Rule Description	Suggested MHP Action Steps
§438.3(h)	Inspection and audit of records and access to facilities	Update P&Ps
§438.3(u)	Recordkeeping requirements	Update P&Ps Inventory records/storage capacity
§438.10	Information Requirements	Update P&Ps Update County portion – handbook Update written materials – language and format requirements Update provider directory
§438.230	Sub-contractual relationships and delegation	Update P&Ps Update provider subcontracts
§438.332	State review of accreditation status	Report to DHCS if accredited
Subpart F (§438.400-438.424	Grievance and appeal systems	Update P&Ps Revise posted notices and signs Update grievance and appeal forms Update Logs Notify network providers

Priorities for Implementation

Citation	Rule Description	Suggested MHP Action Steps
§438.602(d)	Federal database checks	Update P&Ps
§438.608(a)	Program integrity requirements	Update P&Ps Update compliance plan
§438.610	Prohibited affiliations	Update P&Ps
§438.808	Exclusion of entities	Update P&Ps

Priorities Pending Forthcoming DHCS Guidance

- §438.3(m) - Audited Financial Reports
- §438.14 - Requirements that apply to managed care contract involving Indians, IHCPs
- §438.214 - Provider Selection
- Subpart F (§438.400-438.424) - Grievance and Appeal Systems
- §438.602(i) - Entities located outside the U.S.
- §438.604 - Data, information and documentation that must be submitted
- §438.608(d) - Treatment of recoveries of overpayments
- Subpart K – Mental Health and Substance Use Disorder Parity

Additional Updates

- MHP Contract
  - CMS Review
  - CBHDA Review
- TA Contract
  - Harbage Consulting
  - Effective August 15, 2017
- Network Adequacy Standards

DHCS Contact Information

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SAN BERNARDINO COUNTY:
DEVELOPING AND EXECUTING A FINAL RULE WORK PLAN

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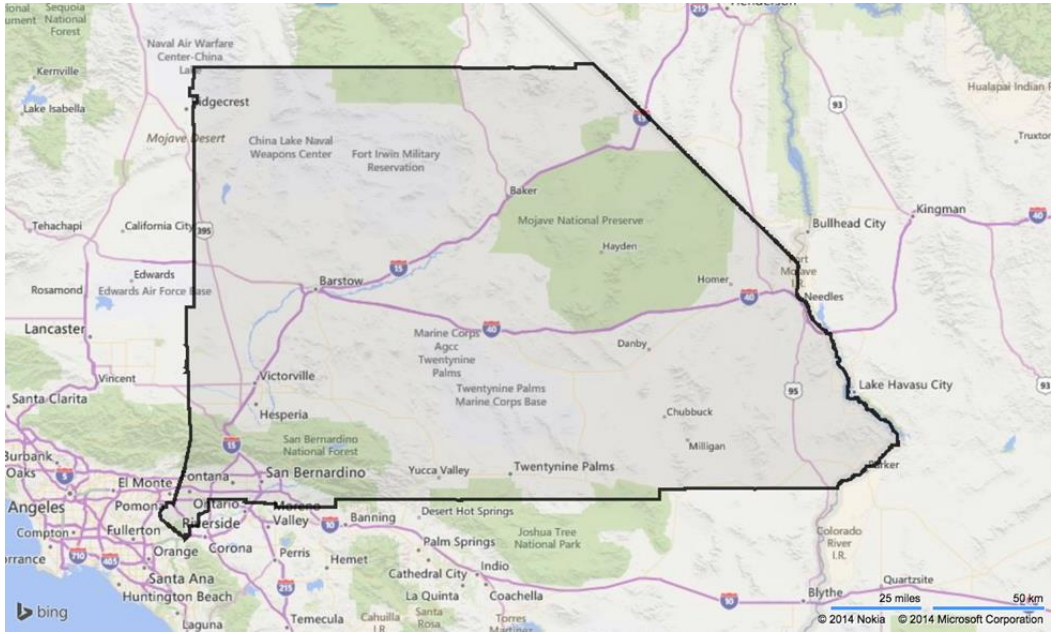

San Bernardino: Large County Perspective

Developing and Executing a Final Rule Work Plan

Marina Espinosa, Deputy Director, Program Support Services

Dr. Rebecca Ballinger, Interim Chief Quality Management Officer, Quality Management Division

Overview of San Bernardino Approach

- Review available tools/resources
  - CMS Checklist for Final Rule
  - County Architect/Project Manager for MMC Adoption tool
  - Regulations
  - CBHDA Fact Sheets
  - Other counties' websites
  - Proposed DHCS contract template document
- Determine partners to assist in development and implementation
- Identify what, if any, is already completed
- Prioritize requirements
  - Estimate timeframes to complete
  - Identify requirements with potential new cost(s)
- Get started

Tools: Organizational

County Architect/Project Manager for MMC Adoption:

Policy & Procedure Analyst:

Consult the final rule for any and all suggestions here as this resource was compiled by multiple resources and is intended as a guide. This is not a complete or definitive source for all elements contained within the rule. All policy and procedure updates should be submitted to CMS with contract updates, per directives from CMS. Policy changes should be grouped by major categories like "beneficiary informing materials" to cross reference.

				Task Manager - Status - See Comment for Insructions							
Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Forms/Standard Templates	Update provider contracts	Inform Clinical Providers (Communications)	Train Staff & Document Training	Assigned	Notes on Status
1-Jul-17	Beneficiary Informing - Website	508 Guidelines, 504 and W3C's	Web format is readily accessible by modern accessibility standards - Assign to technology officer regarding website design for separate task list.								Contact IT for compliance in this area
1-Jul-17	Beneficiary Informing - Materials	438.10	Member informing materials must be printable and given to beneficiaries within 5 business days. (During Enrollment)		X			X			Dicuss with Marina if DBH is responsible for this?
1-Jul-17	Beneficiary Informing - Materials	438.10	Plan must have mechanisms to help enrollees and potential enrollees understand the benefits of the plan.								Enrollment
1-Jul-17	Beneficiary Informing - Translation	438.10	Oral interpretation/translation services in all languages (not just threshold).		X	X					NOAs and grievance forms. Which languages are required?
1-Jul-17	Beneficiary	438.10	All written materials must include taglines in the prevalent non-English								NOAs and grievance forms. Which languages

Grouping by Topic

APPEALS AND GRIEVANCES	STATUS
1. IN-for form updating	Sent out 7/3/17
2. Appeal and Grievance notices - available in the prevalent non-English languages [in the county]	In Process
3. The MHP must have a grievance and appeal system that meets the requirements of subpart F (overall). General requirements are: Each Plan must have a grievance and appeal system in place for enrollees 1) Each Plan may have only one level of appeal for enrollees 2) An enrollee may file a grievance and request an appeal 3) An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld 4) In the case of a Plan that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the Plan's appeals process and the enrollee may initiate a State fair hearing. 5) The State may offer and arrange for an external medical review 6) With the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee	Noted in 1) Grievance procedure, 2) appwal procedure, 3) grievance and appeal policy. These docuements sent out 7/5/17 for review.
4. Appeal and grievance definitions - Appeal means a review by a Plan of an adverse benefit determination 1) Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to: other quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee failure to respect the enrollee's rights regardless of whether remedial action is requested, an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. 2) Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. 3) State fair hearing means the process set forth in subpart E of part 431 of this chapter.	Noted in 1) Grievance procedure, 2) appwal procedure, 3) grievance and appeal policy. These docuements sent out 7/5/17 for review.
5. An enrollee may file a grievance with the Plan at any time. 1) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the Plan. 2) Following receipt of a notification of an adverse benefit determination by a Plan, an enrollee 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. 3) The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.	Noted in 1) Grievance procedure, 2) appwal procedure, 3) grievance and appeal policy.

Priorities

- Documents
  - Grievance and appeals
  - Notice of adverse benefit determination
  - Beneficiary informing materials
- Contract language
- Education with staff and contractors
- Recordkeeping requirements

It Takes A Village

- Quality Management to facilitate and take lead but not necessarily to complete all the required actions at once
- Benefit of large county: different people manage different programs
  - New contract language → DBH Contracts Division
  - Website requirements → Information Technology
  - Auxillary Aids/Alt. Formats → Cultural Competency
  - Update forms → Policy Management
  - Program Integrity → Compliance
  - Requirements w/potential costs → Fiscal

Department Partner Assignments

Final Rule Partners		
Category	**Requirement**	**Partner**
Beneficiary Informing	Website	IT
Beneficiary Informing Materials - Provider Directory	Alternate formats (Braille or Audio) and Auxillary Aids TTY/TDY and American Sign Language	Office of Cultural Competency and Ethnic Serivces
Beneficiary Informing Materials	Alternate formats (Braille or Audio) and Auxillary Aids TTY/TDY and American Sign Language)	Contracts
Data, Information & Documentation	Submit data to the State: Demonstrate that MHP has made adequate provisions against risk of insolvency, MHP Certification data, adequacy of provider network, annual report of overpayment recoveries.	R & E
Program Integrity - Compliance Program	Procedures to detect and prevent fraud, waste and abuse	Compliance
Program Integrity - Compliance Program	Written policies, procedures, and standards of conduct. Designation of a Compliance Officer who reports directly to the CEO and the Board of Directors	Compliance
Program Integrity - Fraud Reporting	Provision for the MHP's suspention of payment to a network provider when the State determines there is a credible allegation of fraud.	Compliance and Contracts

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BUTTE COUNTY PERSPECTIVES

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Butte County's Implementation Approach

Laura Williams, Compliance Officer

Overview of Butte County's Approach

- 1) TRACK: Adopted San Bernardino's checklist into a work plan for Butte to track, monitor, and triage tasks and process updates
- 2) COMMUNICATE: Provide regular updates to multiple levels of leadership to alert to changes and elicit feedback on implementation efforts
- 3) TRIAGE: Quality Management Division reviewed tasks and triaged those which can be accomplished with limited guidance
  - Policy and process updated for Grievances and Appeals
  - Policy update for NOABD, prepared plan to update to NOA BD in form and practice
  - Updated Policies related to Program Integrity/Compliance

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Long Term Implementation Strategy

- Provide ongoing updates on deadlines and deliverables to ensure all departments required to change in response to regulation are on track with implementation
- Continue discussions on how the impact of this shifts operations and agency culture:
  - Where can we be nimble? Where do we have some barriers or challenges?
- Retain any current processes that are already aligned with the Final Rule (If it's not broken…. Don't mess with it!)

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MARIPOSA COUNTY PERSPECTIVES

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Mariposa County

Small Rural Perspective

Christine Doss, Deputy Director, Behavioral Health
Lynn Rumfelt, QA Analyst, Behavioral Health

Implementation Work Plan

- Reviewed CBHDA information and DHCS presentation
- Developed a list of actions from San Bernardino's "Check List for Counties" and reviewed requirements
- Organized the list by priority and grouped with similar tasks
- Provided training to the Management Team of the update in regulations
- Created work groups for more complicated projects

Small County Perspective

BENEFITS

- Mariposa County has one site and one contract provider
- Regular BH staff meetings which allow for dissemination of information
- Centralized QA unit able to provide effective feedback to processes
- QA staff have been trained and are able to provide guidance and support on updated regulations

Small County Perspective

CHALLENGES

- Website Update
- Compliance with ADA standards
- Two QA staff regulate all BH programs
- Changing culture of staff to understand how regulations support good client care
- Beneficiary Handbook update
- Train staff to be able to audit implemented updates
- Time and distance requirements
- Locating a satellite site that meets ADA compliance

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COUNTY DISCUSSION

Additional Resources

- CBHDA Federal Regulations Resources Page: http://www.cbhda.org/member-info/committees/medi-cal-policy/federal-regulations-resources/

- Summary of DHCS Priorities for Implementation
  - Includes links to regulatory language
  - Parallel's Autumn's presentation (see slides 15-17)

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Additional Resources Con't

- Timelines for Implementation:
  - 2017 provisions by category and links to regulatory language: http://www.cbhda.org/wp-content/uploads/2017/03/CBHDA_MMC_Final_Rule_7-1-17-Provisions.pdf
  - MHP Sections of Impact (2016 and beyond) sortable by category, regulatory section, and implementation date
    - See CBHDA Federal Resource Page>CBHDA Resources>Implementation Dates
- Other Resources Available to Counties*:
  - MHP Contract Crosswalk
  - CMS Contract Checklist
  - San Bernardino County Work Plan

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