



Drug Medi-Cal Organized Delivery System Pilot Program Beneficiary Protections

Presentation to Counties
March 10, 2016

Overview of Presentation

2

- **Managed Care Implications**
- **Federal Managed Care Requirements / Regulations**
 - ▣ Enrollee Rights and Protections
- **County Responsibilities under DMC-ODS Pilot Program**
 - ▣ Access / Network Adequacy
 - ▣ Beneficiary Access Line
 - ▣ Beneficiary Informing
 - ▣ Grievance System
 - ▣ Care Coordination
 - ▣ Quality Assessment and Performance Improvement
 - ▣ Utilization Management
- **State Oversight, Monitoring, and Reporting Requirements**

Presenters

3

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DMC-ODS: A Managed Care Program

4

- **Managed Care.** Under managed care, beneficiaries receive part or all of their Medicaid services from providers who are paid by an organization (i.e. county) that is under contract with the state.
- **DMC Pilot Counties as Managed Care Plans.** Counties participating in the DMC-ODS Pilot Program will be considered managed care plans.
 - ▣ **Prepaid Inpatient Health Plan.** Upon approval of the implementation plan, the State shall enter into an intergovernmental agreement with the County to provide or arrange for the provision of DMC-ODS Pilot services through a “Prepaid Inpatient Health Plan” (PIHP) as defined in federal law.
 - ▣ **Federal Managed Care Requirements.** Accordingly, DMC-ODS Pilot “PIHPs” must comply with federal managed care requirements (some exceptions).

5

Federal Managed Care Requirements

Federal Medicaid Managed Care Requirements

6

- ❑ **Federal Regulations.** Participating counties will be held to federal managed care requirements as outlined in 42 CFR Part 438.
 - ❑ Some exceptions apply / “waived” in the STCs.
- ❑ **Regulatory Changes.** On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rulemaking (NPRM) to modernize federal Medicaid managed care regulations.
 - ❑ If finalized during the term of the pilot, there may be important implications for DMC-ODS Pilot Counties.

Federal Regulations – General Categories (Subparts)

7

- ❑ General Providers
- ❑ State Responsibilities
- ❑ **Enrollee Rights and Protections**
- ❑ Quality Assessment and Performance Improvement
- ❑ External Quality Review
- ❑ Grievance System
- ❑ Certifications and Program Integrity
- ❑ Sanctions
- ❑ Conditions for Federal Financial Participation

Enrollee Rights and Protections

8

- ❑ **Enrollee Rights** (42 CFR §438.100)
- ❑ **Provider-Enrollee Communications** (42 CFR §438.102)
- ❑ **Marketing Activities** (42 CFR §438.104)
- ❑ **Liability for Payment** (42 CFR §438.106)
- ❑ **Cost Sharing** (42 CFR §438.108)
- ❑ **Emergency and Post-Stabilization Care** (42 CFR §438.114)
- ❑ **Solvency Standards** (42 CFR §438.116)

Enrollee Rights and Protections: Enrollee Rights

9

- **Written Policies.** Each plan must have written policies regarding enrollee rights.
- **Compliance.** Each plan must comply with any state or federal laws that pertain the enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services.
- **Free Exercise of Rights.** The state must ensure that each enrollee is free to exercise his / her rights.
- **Compliance with Other Federal and State Laws.** The state must ensure that the plan complies with any other applicable federal and state laws related to patient rights (i.e. ADA, confidentiality)

Enrollee Rights and Protections: Enrollee Rights

10

Enrollee rights include:

- Receive information in accordance with federal requirements (i.e. easily understood, available in prevalent non-English languages, etc.)
- Be treated with respect and due consideration for his /or dignity and privacy
- Receive information on available treatment options and alternatives
- Participate in decisions regarding his / her health care, including right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive copy of medical records, and request that they be amended or corrected (if privacy rule applies)

Enrollee Rights and Protections: Provider-Enrollee Communications

11

- ❑ **Provider as Patient Advisor / Advocate.** A plan may not prohibit, or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his/her patient, for the following (with some exceptions):
 - ❑ The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - ❑ Any information the enrollee needs in order to decide among all relevant treatment options.
 - ❑ The risks, benefits, and consequences of treatment and non-treatment.
 - ❑ The enrollee'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.

Enrollee Rights and Protections: Liability for Payment

12

- Each plan must provide that its Medicaid enrollees are not held liable for any of the following:
 - The plan's debts in the event of the entity's insolvency
 - Covered services provided to the enrollee for which:
 - The state does not pay the plan
 - The state or plan does not pay the individual provider that furnishes the services under a contractual, referral, or other arrangement
 - Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the plan provided the services directly

Enrollee Rights and Protections: Emergency and Post-Stabilization Care

13

- **Emergency Services.** Medical Attention for emergency and crisis medical conditions must be provided immediately (pg.105 of STCs).
 - ▣ **Emergency medical condition:** A condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson could reasonably expect the absence of immediate medical attention to result in placing health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.
- **Post Stabilization Care.** Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or improve the enrollee's health.
- **Coverage and Payment.** To the extent that the services required to treat an emergency condition fall within the scope of services for which the plan is responsible, federal rules regarding coverage and payment apply.
- **Authorization.** Prior authorization is not required for emergency services.

14

County Responsibilities under the DMC-ODS Pilot Program

County Responsibilities under DMC-ODS Pilot Program

15

- **Selective Provider Contracting**
 - ▣ Selection Criteria / Policies
 - ▣ Contract Denial / Appeal Process
 - ▣ Medical Director / Risk Screening Requirements
- **Access**
 - ▣ NTP Access
 - ▣ Network Assurances / Monitoring
- **Authorization for Residential**
- **Beneficiary Access Number**
- **Beneficiary Informing**
- **Grievance System**
- **Care Coordination**
- **Quality Assessment and Performance Improvement**
- **Utilization Management**



Access

16

- **Accessible Services.** Each county must ensure that all required services covered under the pilot are available and accessible to enrollees.
- **Out of Network Coverage.** If the county is unable to provide services, the county must adequately and timely cover these services out-of-network for as long as the county is unable to provide them.
- **Appropriate and Adequate Network.** The county shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors and sufficient to provide adequate access.
- **Provider Selection.** Access cannot be limited in any way when counties select providers.
- **Timely Access.** Hours of operation are no less than those offered to commercial enrollees or comparable Medi-Cal FFS, if provider only services Medi-Cal. Includes 24/7 access, when medically necessary.
- **Cultural Considerations.** Pilot county participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including LEP and diverse cultural / ethnic backgrounds.
- **Monitoring.** Monitor providers regularly to determine compliance and take corrective action if there is a failure to comply.

Network Adequacy

In establishing and monitoring a network, pilot counties must consider:

- **Timely Access Standards.** Ability of providers to meet Department standards for timely access to care and services as specified in the county implementation plan and contract.
- **Emergency and Crisis Care.** Ability to assure that medical attention for emergency and crisis medical conditions be provided immediately.
- **Number of Eligibles.** The anticipated number of Medi-Cal eligible clients.
- **Utilization.** The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
- **Number / Type of Providers.** The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
- **Providers Not Accepting New Patients.** The number of network providers who are not accepting new beneficiaries.
- **Geography.** The geographic location of providers and their accessibility to beneficiaries, considering:
 - ▣ Distance
 - ▣ Travel Time
 - ▣ Means of Transportation Ordinarily Used by Medi-Cal Beneficiaries
 - ▣ Physical Access for Disabled Beneficiaries

Beneficiary Access Number

18

- **24/7 Toll-Free.** All pilot counties shall have a 24/7 toll free number for prospective beneficiaries / enrollees to call to access DMC-ODS services.
- ▣ **Interpretation Services.** Oral interpretation services must be made available for beneficiaries, as needed.

Beneficiary Informing Requirements

19

- **Amount, Duration, Scope of Services.** Pilot counties shall inform beneficiaries about the amount, duration, and scope of services under this waiver.
 - ▣ Information must be provided upon first contact with a beneficiary or referral
 - ▣ Must be in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
- **Language.**
 - ▣ The pilot county must make written information available in each prevalent non-English language.
 - ▣ Oral interpretation services available free of charge, including in all non-English languages
- **Format.**
 - ▣ Informational materials must be provided in a manner and format that may be easily understood

Beneficiary Informing Requirements: Minimum Required Information

20

- **Minimum Required Information.** Pilot counties must, at minimum, provide the following information to enrollees:
 - Names, locations, telephone numbers, and non-English languages spoken by current contracted providers
 - Any restrictions of the enrollee's freedom of choice among network providers
 - Enrollee rights and protections
 - Information on grievance and fair hearing procedures
 - The amount, duration, and scope of benefits available
 - Procedures for obtaining benefits, including authorization requirements
 - The extent to which, and how, enrollees may obtain benefits from out-of-network providers
 - The extent to which, and how, after-hours and emergency coverage are provided
 - Post-stabilization care rules
 - Policy on referrals for specialty care and other benefits
 - Cost sharing, if any
 - How and where to access any benefits that are covered under the state Medicaid plan, but not under the Pilot contract.

Grievance System

21

□ **State Requirements.**

- Provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon properly.
- Provide for methods of administration necessary for the proper and efficient operation of the plan (county).

□ **Plan Requirements.**

- Each pilot county must establish internal grievance procedures under which Medi-Cal enrollees, or providers on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- The county's "grievance system" must include a grievance process, appeal process, and access to the State's fair hearing process.

Grievance System

22

- General Descriptions / Requirements
- Timing & Procedures
- Notice of Action / Timing of Notice
- Handing of Grievances & Appeals
- Resolution & Notification
- State Fair Hearing
- Expedited Resolution of Appeals
- Information about Grievance System to Providers
- Recordkeeping & Reporting
- Continuation of Benefits while Appeals / State Hearing Pending
- Effectuation of Reversed Appeal Resolution

Grievance System: Appeals

23

- Appeal means a request for review of an “action”
- “Actions” include:
 - Denial or limited authorization of a requested service, including the type or level of service;
 - Denial, suspension, or termination of a previously authorized service;
 - Denial, in whole or in part, of payment for a service;
 - Failure to provide services in a timely manner, as defined by the State;
 - Failure of the pilot county to act within the specified timeframes;
 - Denial of a request to obtain services outside of the network.

Grievance System: Grievances

24

- “Grievance” means an expression of dissatisfaction about any matter other than an “action.”
- Possible subjects for grievances include, but are not limited to:
 - The quality of care of services provided
 - Aspects of the interpersonal relationships such as rudeness of a provider or employee;
 - Failure to respect the enrollee’s rights

Grievance System: Timing & Procedures

25

- **Timing.** The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the county's notice of action. Within that timeframe:
 - ▣ The enrollee or provider may file an appeal
 - ▣ The enrollee may request a State fair hearing
- **Procedures.**
 - ▣ The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the pilot county.
 - ▣ The enrollee or provider may file an appeal either orally or in writing, and unless he or she request expedited resolution, must follow an oral filing with a written, signed, appeal.

Grievance System: Notice of Action

26

- **Language and Format Requirements.** The notice must be in writing and must meet the language and format requirements specified in federal law to ensure ease of understanding.
- **Content of the Notice.** The notice must explain the following:
 - The action the county or its contractor has taken or intends to take.
 - The reasons for the action.
 - The enrollee's or the provider's right to file an appeal.
 - The enrollee's right to a fair hearing.
 - The procedures for exercising these rights.
 - The circumstances under which expedited resolution is available and how to request it.
 - The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of the services.

Grievance System: Timing of Notice

27

- **The county must mail the notice within the following timeframes:**
 - For terminations, suspension, or reduction of previously authorized Medicaid-covered services, within the specified timeframes.
 - For denial of payment, at the time of any action affecting the claim.
 - For standard service authorization decisions that deny or limit services, within the specified timeframe.
 - If the county extends the timeframe, it must:
 - Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he/she disagrees with that decision.
 - Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
 - For service authorization decisions not reached within the timeframes specified (which constitutes a denial and is thus an adverse action), on the date that the timeframe expires.
 - For expedited service authorization decisions, within the specified timeframes.

Grievance System: Handling of Grievances and Appeals

28

- In handling grievances and appeals, each county must:
 - **Reasonable Assistance.** Give enrollees any reasonable assistance in completing forms and taking other procedural steps (i.e. interpreter services, toll-free numbers, TTY/TTD)
 - **Acknowledgement.** Acknowledge receipt of each grievance and appeal
 - **Appropriate / Qualified Reviewers.** Ensure that the individuals who make decisions on grievances / appeals:
 - Were not involved in any previous level of review or decision-making and;
 - Who, if deciding on any of the following, are health care professionals with appropriate clinical expertise in treating the condition:
 - A denial that is based on lack of medical necessity
 - Denial of expedited resolution of an appeal
 - Involves clinical issues

Grievance System: Special Requirements for Appeals

29

- The process for appeals must:
 - **Oral Appeals Confirmed in Writing.** Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
 - **Opportunity for Evidence.** Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
 - **Access to File.** Provide the enrollee and his/her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process
 - **Included Parties.** Include, as parties to the appeal:
 - The enrollee and his/her legal representative
 - The legal representative of a deceased enrollee's estate

Grievance System: Timeframes for Resolution and Notification

30

- **Standard Disposition of Grievances.** The timeframe established by the state may not exceed 90 days from the day the county receives the grievance.
- **Standard Resolution of Appeals.** The state must establish a timeframe that is no longer than 45 days from the day the county receives the appeal. This timeframe may be extended up to 14 days in specified circumstances.
- **Expedited Resolution of Appeals.** The state must establish a timeframe that is no longer than 3 working days after the county receives the appeal. This timeframe may be extended up to 14 days in specified circumstances.

Grievance System: Format and Content of Notices

31

- **Format of Notice.**
 - ▣ **Grievances.** The state must establish the method counties will use to notify an enrollee of the disposition of a grievance.
 - ▣ **Appeals.**
 - The county must provide written notice of disposition.
 - For an expedited resolution, the plan must also make reasonable efforts to provide oral notice.
- **Content of Notice of Appeal Resolution.** The written notice must include the following:
 - ▣ **Results / Date.** The results of the resolution process and the date it was completed.
 - ▣ **Unfavorable Resolutions.** For appeals not resolved wholly in favor of the enrollee:
 - The right to request a State fair hearing and how to do so
 - The right to request to receive benefits while the hearing is pending, and how to make the request
 - That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the county's action.

Grievance System: State Fair Hearings

32

- **Availability.** The state must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State.
 - ▣ Must not be less than 20 or in excess of 90 days from the date of the county's notice of resolution.
- **Parties.** The parties to the State fair hearing include:
 - ▣ The county
 - ▣ The enrollee and his/her representative or the representative of a deceased enrollee's estate.

Grievance System: Expedited Resolution of Appeals

33

- **General Rule.** Each county must establish and maintain an expedited review process for appeals when the county determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
- **Punitive Action.** The county must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
- **Action Following Denial of a Request for Expedited Resolution.** If the county denies a request for expedited resolution of an appeal it must:
 - Transfer the appeal to the timeframe for standard resolution
 - Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow-up within two calendar days with a written notice

Grievance System: Information to Providers and Record-Keeping

34

- **Information to Providers and Subcontractors.** The county must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.
- **Record-Keeping and Reporting.** The State must require counties to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

Grievance System: Continuation of Benefits

35

- **Timely Filing.** Timely filing means filing on or before the later of the following:
 - ▣ Within ten days of the county mailing the notice of action
 - ▣ The intended effective date of the county's proposed action.
- **Continuation of Benefits.** The county must continue the enrollee's benefits if:
 - ▣ The enrollee or the provider files the appeal timely
 - ▣ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
 - ▣ The services were ordered by an authorized provider
 - ▣ The original period covered by the original authorization has not expired
 - ▣ The enrollee requests extension of benefits

Grievance System: Duration of Continued / Reinstated Benefits

36

- **Duration of Continued or Reinstated Benefits.** If, at the enrollee's request, the county continues / reinstates benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - The enrollee withdraws the appeal.
 - Ten days pass after the county mails the notice, providing the resolution of the appeal "against" the enrollee, unless the enrollee, within 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
 - A State fair hearing office issues a hearing decision adverse to the enrollee
 - The time period or service limits of a previously authorized service has been met.
- **Enrollee Responsibility for Services Furnished while the Appeal is Pending.** If the final resolution of the appeal is adverse, the county may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the appeal.

Grievance System: Reversed Appeal Resolutions

37

- **Services Not Furnished while the Appeal is Pending.** If the county, or state fair hearing, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the county must authorize and provide the disputed services promptly.
- **Services Furnished while the Appeal is Pending.** If the county, or state fair hearing office, reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the county must pay for those services.

Care Coordination

38

- **Federal Requirement for Care Coordination.** Each “plan” must implement procedures to deliver primary care to and coordinate health care service for all enrollees. These procedures must:
 - ▣ **Primary Care.** Ensure ongoing source of primary care
 - ▣ **Coordination with Other Plans.** Coordinate services furnished to an enrollee with services the enrollee receives from any other plan.
 - ▣ **Sharing Assessments.** Share with plans serving an enrollee with special health care needs the results of its assessment to prevent duplication of activities.
 - ▣ **Privacy.** Protect privacy in accordance with the privacy requirements.
- **Pilot County Care Coordination Plan.** Pilot counties must describe in implementation plan / contract a care coordination plan for achieving seamless transitions of care.
- **MOU.** Pilot county shall enter into a MOU with any health plan that enrolls beneficiaries served by DMC-ODS.
 - ▣ **Format.** Requirement may be met through an amendment to the existing MOU between the MHP and MCP.
 - ▣ **Content.** Required elements are outlined in the STCs.

Quality Assessment and Performance Improvement

39

- **QA / PI Program.** Each county must have an ongoing quality assessment and performance improvement program for the services it furnished to its enrollees.
- **Min. Federal Requirements.** The state must require that each county:
 - ▣ **PIPs.** Conduct performance improvement projects
 - ▣ **Data.** Submit performance measurement data
 - ▣ **UM.** Have mechanisms to detect both under- and overutilization of services.
 - ▣ **Special Needs.** Have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- **Performance Measurement.** Annually, each county must measure and report its performance to the State and submit data to the State that enabled the State to measure performance
- **Performance Improvement Projects (PIPs).** Counties must have an ongoing program of PIPs that focus on clinical and nonclinical areas.
- **Program Review by the State.** The state must review, at least annually, the impact and effectiveness of each county's quality assessment and performance improvement programs (i.e. performance on standard measures, results of PIPs)

Quality Assessment and Performance Improvement: Pilot Requirements

40

- **Quality Improvement (QI) Plan.** Each pilot county must have a QI Plan to monitor the service delivery, capacity, types, and geographic distribution of SUD providers.
 - ▣ For counties with an integrated MH/SUD department, this QI plan may be combined with the MHP QI plan
- **QI Committee.** Each pilot county shall have a QI Committee to review the quality of SUD services provided to the beneficiary.
 - ▣ Can be integrated with MHP QIC
- **Utilization Management Program.** County shall have a Utilization Management Program
 - ▣ Must have a system for collecting, maintaining, and evaluating accessibility of care and waiting list information

Quality Assessment and Performance Improvement: QI Plan

41

- **QI Plan.** The monitoring of accessibility of services outlined in the QI plan will at minimum include:
 - Timeliness of first initial contact to face-to-face appointment
 - Timeliness of services of the first dose of NTP services
 - Access to after-hours care
 - Responsiveness of the beneficiary access line
 - Strategies to reduce avoidable hospitalizations
 - Coordinate of physical and mental health services with pilot services at the provider level
 - Assessment of the beneficiaries' experiences
 - Telephone access line and services in the prevalent non-English languages.

Quality Assessment and Performance Improvement: QI Committee

42

- **QI Committee.** The QI Committee shall:
 - ▣ Recommend policy decisions
 - ▣ Review and evaluate the results of QI activities
 - ▣ Institute needed QI actions
 - ▣ Ensure follow-up of QI process
 - ▣ Document QI committee minutes regarding decisions and action taken.
- **Quarterly Data Review.** Each County QI Committee should review the following data at minimum on a quarterly basis:
 - ▣ Number of days to first DMC-ODS service at appropriate level of care after referral
 - ▣ Existence of a 24/7 access line with prevalent non-English languages
 - ▣ Access to DMC-ODS services with translation services in the prevalent non-English languages
 - ▣ Number, % of denied and time period of authorization requests approved or denied

43

State Oversight, Monitoring, and Reporting

State Oversight, Monitoring, and Reporting

44

- **Monitoring Plan**
 - ▣ Annual EQRO Review
 - ▣ Timely Access
 - ▣ Program Integrity
- **Reporting of Activity**
- **Triennial Review**
- **ASAM Designation for Residential.**
- **Provider Appeals Process.**

State Oversight: Monitoring Plan

45

- **Annual EQRO**
 - ▣ Must be phased in within 12 months of an approved plan.
 - ▣ Significant deficiencies / evidence of noncompliance will first result in DHCS technical assistance
 - ▣ If county remains non-compliant, must submit a Corrective Action Plan (CAP). Ultimately, could result in dismissal.
- **Timely Access**
 - ▣ Access standards and timeliness requirements are to be specified in the implementation plan
- **Program Integrity**
 - ▣ State shall conduct a site monitoring review of every site through which the provider furnishes services
 - ▣ State to review residential facilities to provide ASAM designation prior to providing pilot services.

State Oversight: Triennial Review

46

- **Compliance.** This review provides state with information as to whether or not the pilot county is complying with their responsibility to monitor their service delivery capacity.
- **QI Plan.** State will review the QI plan and county monitoring activities.
- **Final Report.** County will receive a final report summarizing the findings of the review
- **Plan of Correction.** If out of compliance, the county must submit a plan of correction (POC) within 60 days
- **Follow-up.** The state will follow-up with the POC to ensure compliance

Timeline for Pilot Implementation

47

- **Implementation Plan.** Counties must submit to the state a plan for implementation of the DMC-ODS Pilot. Plan to be approved by both DHCS and CMS.
- **Network Requirements.** At least 60 days prior to CMS contract approval, state shall submit applicable network adequacy requirements for each opt-in county.
- **Rates.** Counties must submit proposed interim rates for DHCS approval (i.e. fiscal plan).
- **Contract.** County must also have an executed state/county contract (intergovernmental agreement) subject to county Board of Supervisors and CMS approval.
- **Prospective Implementation.** Upon approval of the plan and executed contract, counties will be able to bill prospectively for services through this pilot.

48

Questions?

California Department of Health Care Services

49



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For More Information:

<http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>



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