Drug Medi-Cal (DMC) Organized Delivery System (ODS) Annual Compliance Training

June 9, 2021

County/Provider Operations & Monitoring
Medi-Cal Behavioral Health Division
Department of Health Care Services

Introduction and Welcome

- PowerPoint slides were sent to all who registered for this training
- We will have time for questions after each section
- Please use the Q & A feature for all questions related to the content of the training

Agenda

- Compliance Trends
- Compliance Review and Corrective Action Plan process
- Frequently Missed Compliance Requirements
- Overview of CalAIM changes affecting DMC-ODS for next 6 years

Current DMC-ODS Landscape

Since 2015:

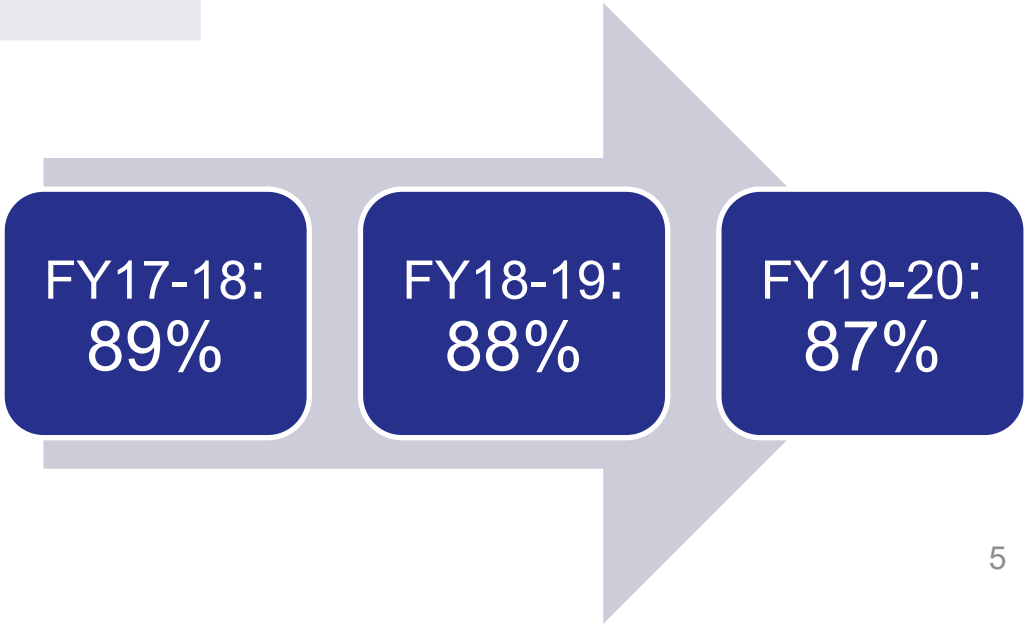
- Total counties in DMC-ODS (including regional model): **37**
- Independent DMC-ODS counties: **30**
- PHC Regional Model counties: **7** (Implemented on July 1, 2020)
- Total percentage of Medi-Cal Population in DMC-ODS county (including regional model): **96%** of total California Medi-Cal eligible population

Compliance trends

FY19-20 Compliance Percentage	Number of counties in this category
91-100%	9
81-90%	15
71-80%	6
70% and below	0

FY 19-20 Compliance rate:
Average 87%
compliance rate amongst 30 DMC-ODS counties reviewed.

Three year average compliance rate trends



Trends from CAP Monitoring Data

Number of total unresolved CAPs FY17-FY20	Number of counties in this category
0	10
1-5	14
6-10	3
11-15	1
15 and over	2

Number FY with unresolved CAPs	Number of counties in this category
0 FY	10
1 FY	10
2 FY	7*
3 FY	3*

* 4 counties working on data integrity issues in CalOMS with DHCS

Compliance Review Process

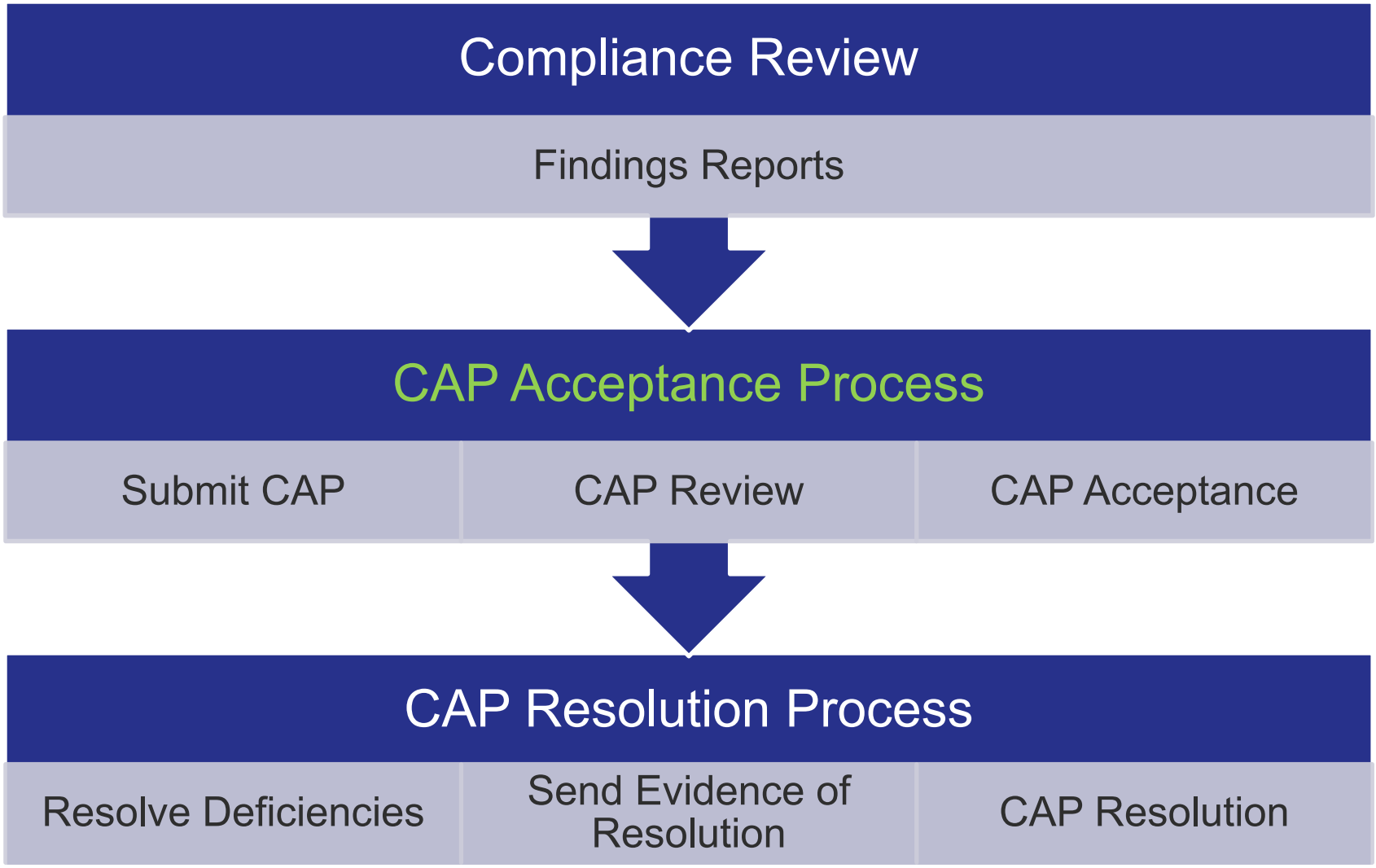
Desk Review of Documentation

- Documents submitted to DHCS and reviewed prior to onsite/webinar

Virtual/Onsite Facilitated Interviews

- Meaningful dialogue with county DMC-ODS representatives
- Seeks to understand the county system and operations

Acceptance & Resolution



CAP Acceptance/Resolution Process

1. CAP Acceptance

   Review CAP and accept the CAP for the county's implementation to ensure the proposed CAP is likely to resolve the identified compliance findings and keep the county in compliance in the future.

2. CAP Resolution

   Review evidence of CAP resolution to confirm identified CAP is resolved, and the county implemented strategies to maintain compliance.

CAP Acceptance Process

1. County submits CAP to DHCS
2. DHCS reviews the CAP for the following:
    a. Addressing all the findings identified in the compliance review findings report
    b. All five elements required in CAP
    c. Completeness of the CAP to not only address immediate finding(s) but for strategies to maintain ongoing compliance in the future
    d. Specifics in the CAP to ensure realistic and attainable CAP goals (e.g., SMART goals)
    e. List of proposed evidence to be submitted to demonstrate resolution of identified findings and strategies to maintain future compliance
3. If the correction is needed
    1. DHCS will work with the county until the CAP can be accepted if the correction is minor
    2. If major correction is needed, DHCS will deny the CAP and will request the county to submit updated CAP
4. DHCS will notify county when the CAP is accepted

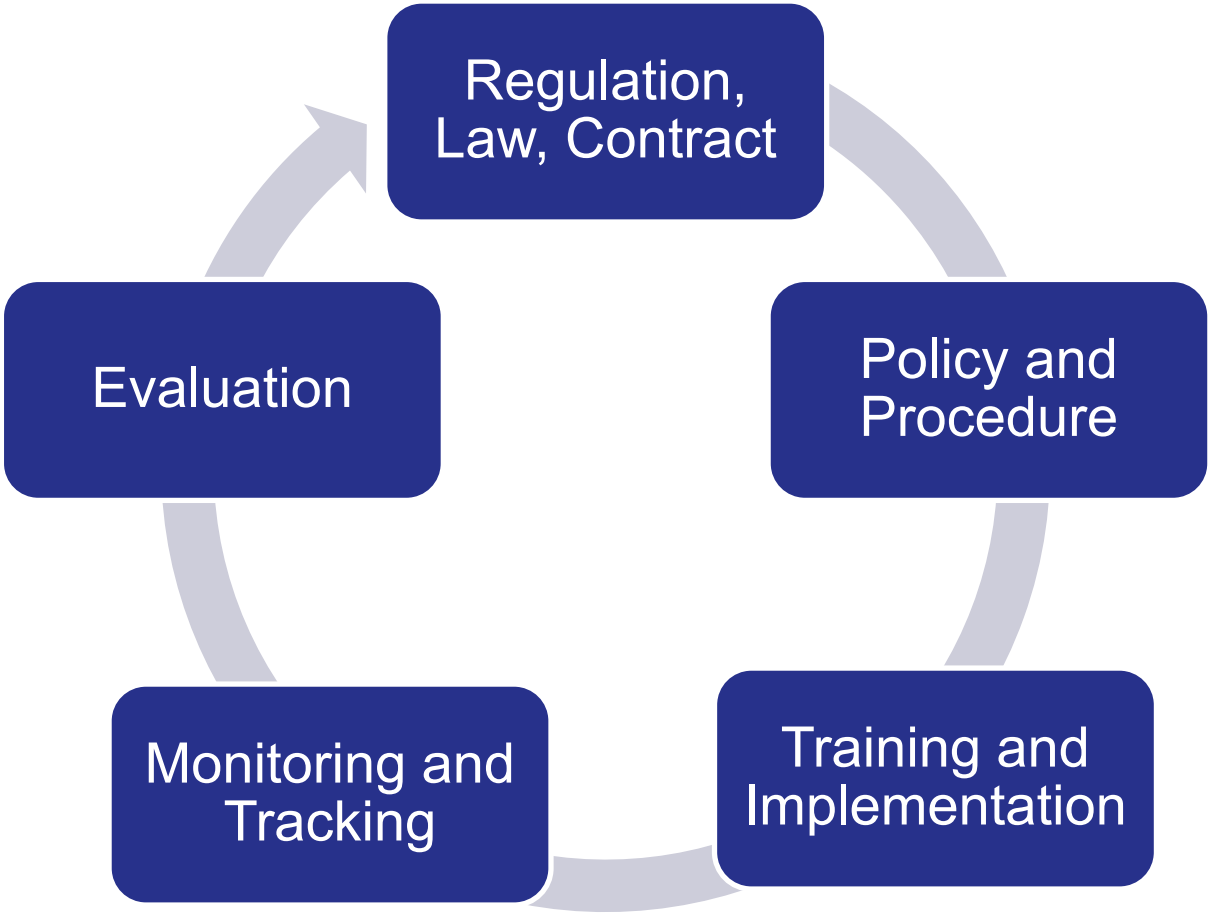
Does CAP include ALL five required elements?

- Ensure submitted CAP addresses the required information:
  1. Be documented on the DHCS CAP template
  2. Provide a specific description of how the deficiency shall be corrected
  3. Identify the title of the individual(s) responsible for correcting the deficiency and ensuring on-going compliance
  4. Provide a specific description of how the provider will ensure on-going compliance
  5. Specify the target date of implementation of the corrective action

Does CAP address all the findings?

- Compare the CAP with the findings reports to ensure there is a CAP to address ALL the compliance deficiencies identified in the findings report(s).

Completeness of CAP
Strategies for future compliance



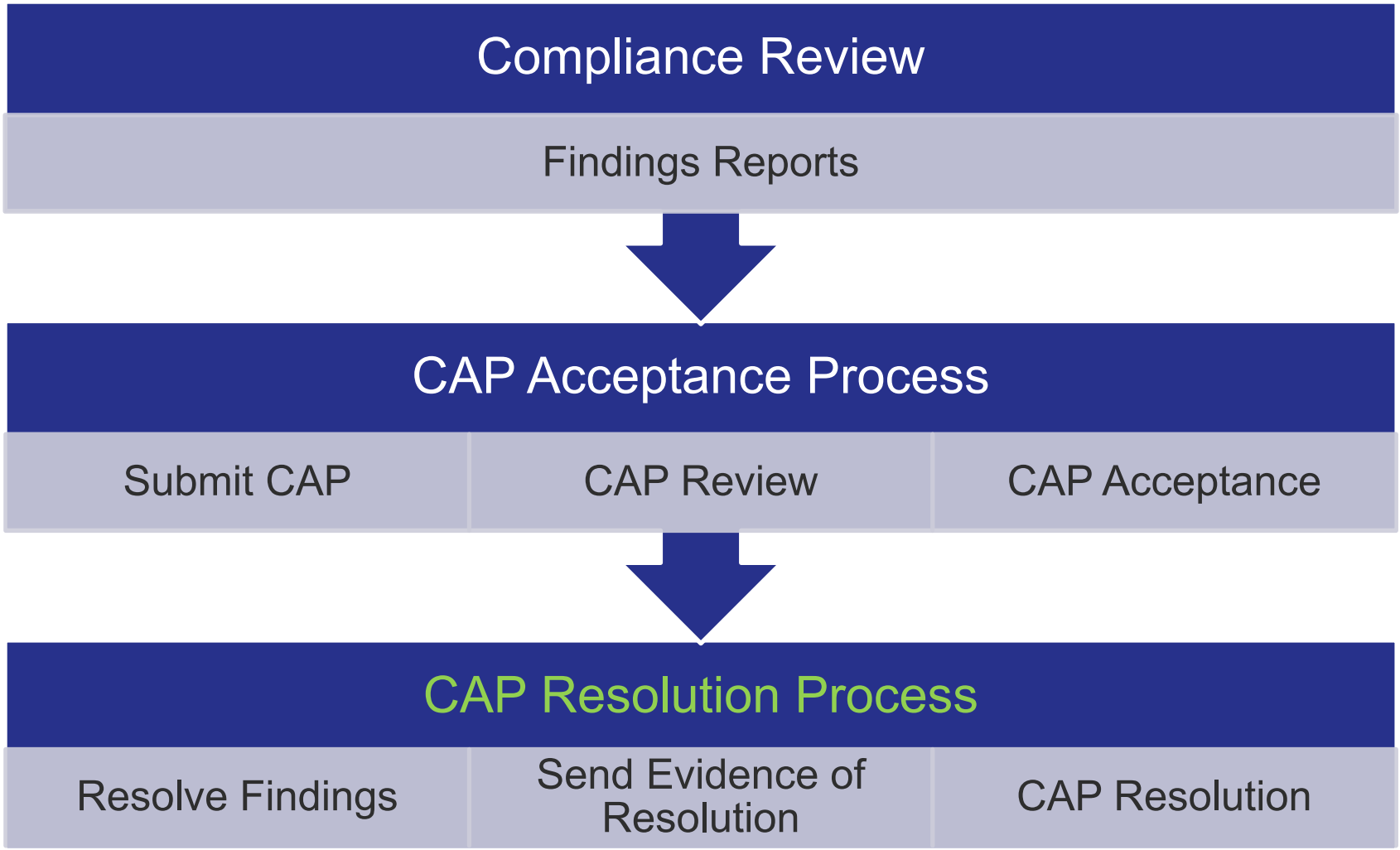
"Does the CAP address the Compliance Cycle to maintain ongoing compliance?"

Is CAP attainable and realistic?

What evidence is county planning to submit?

- How do we know that the proposed evidence will prove that the finding will be resolved and will not happen again?
- Compare the suggested corrective actions vs. proposed evidence
- Will evidence demonstrate that corrective action was taken as described in the CAP?
- Will evidence demonstrate the resolution of the current finding?
- Will evidence demonstrate strategies for the ongoing compliance moving forward?

Acceptance & Resolution



CAP Resolution Process

1. County submits evidence of CAP resolution to DHCS
2. DHCS reviews evidence of CAP resolution
3. DHCS will work with county until the evidence indicates that the finding is entirely resolved, and the county has implemented strategies to monitor for ongoing compliance.
4. Once ALL the findings are resolved, DHCS will notify the county of the CAP resolution.
5. County will continue to monitor for ongoing compliance

Questions?

- Please use the Q & A function on the right hand side of the screen to ask your question

Frequently missed compliance requirements

- CalOMS Data submission
- Medical director requirements
- Frequently missed Reporting requirements
- Provider monitoring
- Coordination of care requirements
- Credentialing requirements
- Professional staff (LPHAs) training requirement
- 24/7 access line requirements
- Grievances & Appeals
- NOABDs
- Provider directory requirements
- Web posting requirements
- Quality Management (QM) Program
- Quality Improvement Committee (QIC) requirements

CalOMS Data Submission

- **<u>Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 4, i, c-f</u>:** Non-compliant CalOMS-Treatment reports. Open providers report and open admissions report
- **The CalOMS-Treatment business rules and requirements are:**
  - Electronic submission of CalOMS-Treatment data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
  - Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Treatment Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Treatment data collection and reporting requirements.

CalOMS Data Submission

- Contractor shall submit CalOMS-Treatment admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and “provider no activity” report records in an electronic format approved by DHCS.
- Contractor shall comply with the CalOMS-Treatment Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method

Medical director related requirements

- Code of conduct
  - **Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, iii, a-i**
    - Code of Conduct is missing elements and not signed by both medical director and provider representative
- Written role and responsibility
  - **Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7, v**
    - Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.

Medical director related requirements

- **Medical Director standards**
  - The substance use disorder medical director's responsibilities shall, at a minimum, include all of the following:
    a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
    b. Ensure that physicians do not delegate their duties to non- physician personnel.
    c. Develop and implement medical policies and standards for the provider.
    d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
    e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
    f. Ensure that provider's physicians are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries and perform other physician duties, as outlined in this section.

Medical director related requirements

- Continuing education requirements
  - **Intergovernmental Agreement Exhibit A, Attachment I, III, A, 1, iv-v**
    - Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
    - Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year

Frequently missed reporting requirements

- **Provision for prompt reporting of all overpayments identified or recovered**
  - The Contractor and all its subcontractors shall provide reports to the Department within 60 calendar days when it has identified payments in excess of amounts specified in the Contract.
  - **INFORMATION NOTICE NO. 19-034:**
    - This information notice provides guidance to Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties, herein referred to as Plans, on their obligations to recover and report overpayments made by the Plans to their contracted providers per the Federal Medicaid Managed Care Final Rule (Final Rule) and the Federal Mental Health and Substance Use Disorder Services Parity Final Rule (Parity Rule) requirements.
  - **INFORMATION NOTICE NO. 19-022:**
    - The Contractor shall annually report to the Department on their recoveries of overpayments.

Frequently missed reporting requirements

- **Procedure for reporting any potential fraud, waste, or abuse**
  - Does the Plan have a procedure for reporting any potential fraud, waste, or abuse to DHCS?
    - **Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, i-ii, a, i-vii:** The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

Frequently missed reporting requirements

- The arrangements or procedures shall include the following:
  - Written policies, procedures, standards that comply with all applicable Federal and state requirements.
  - Compliance Officer is responsible for developing policies, procedures, and practices.
  - Regulatory Compliance Committee
  - A system for training and education
  - Effective lines of communication
  - Enforcement and standards
  - Establishment and implementation of procedures and a system with dedicated staff for routine internal auditing and monitoring.
- Suspected Medi-Cal fraud, waste, or abuse must be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

Provider monitoring activities and reports

- **Intergovernmental Agreement Exhibit A, Attachment I, III, OO, 1, i, d**: Missing monitoring reports or not sent to DHCS within required timeframe.
  - Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements.
  - Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance.
  - Reports should be sent by secure, encrypted e-mail to: sudcountyreports@dhcs.ca.gov

Coordination of care requirements

- Does the Plan have coordination of care procedures its providers must follow?
- **Intergovernmental Agreement Exhibit A, Attachment I, II, G, 1**
  - Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care.
  - Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

Coordination of care requirements

- In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
- Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.
- Coordination of care and continuity of care requirements consist of a reassessment and transitions of other levels of care.

Questions?

- We will now answer questions received through the Q&A

Credentialing requirements

- Written policy and procedures for selection and retention of network providers meet the following requirements:
  - Follows the state's established credentialing and re-credentialing policy outlined in IN 18-019;
  - Does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment;
  - Prohibits employing or subcontracting with providers excluded from participation in Federal health care programs, including Medicare or Medicaid/Medi-Cal; and
  - Complies with any additional requirements established by DHCS.
- 42 CFR §438.214 and IN 18-019

Professional staff (LPHAs) training requirement

- Receive a minimum of five (5) hours of continuing education related to addiction medicine each year.
- Licensed Professional of the Healing Arts (LPHAs) include:
  - Physicians
  - Nurse Practitioners
  - Physician Assistants
  - Registered Nurses
  - Registered Pharmacists
  - Licensed Clinical Psychologists
  - Licensed Clinical Social Workers
  - Licensed Professional Clinical Counselors
  - Licensed Marriage and Family Therapists
  - License Eligible Practitioners working under the supervision of licensed clinicians

24/7 access line requirements

- A toll-free 24/7 beneficiary access line (BAL) to beneficiaries seeking access to SUD services.
- Publish BAL information on the Plan's web page, on all information brochures, and prevention materials in all threshold languages.
- 24/7 BAL must:
  - Provide referrals to services for urgent conditions and medical emergencies 24/7.
  - Provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language

24/7 access line requirements

- Beneficiaries determined to be in crisis shall be immediately linked to appropriate support and management.
- Beneficiaries screened as having an urgent need will be referred for an appointment with qualified staff within one (1) business day.
- The Plan must provide eligible, non-urgent beneficiaries a face-to-face appointment with the appropriate LOC provider within ten (10) business days from the initial referral.

Grievance and Appeals Requirements

- Grievance/Appeal Acknowledgement
  - Written, include: date received and the name, phone number and address of Plan representative, and be postmarked within 5 calendar days of receipt.
- Notice of Grievance Resolution (NGR) / Notice of Appeal Resolutions (NAR)
  - Utilize provided templates, see BHIN 18-010E
  - Ensure a clear and concise explanation of the Plan's decision is included.
  - NAR must be sent with the NAR "Your Rights" Attachment.

Grievance and Appeal Requirements

- Grievance resolution timeframes
  - Resolve grievances in 90 calendar days, unless specified.
  - Grievances related to the plans decision to extend the time frame for making an authorization decision must not exceed 30 calendar days.
- Appeal resolution timeframes
  - Resolve appeals in 30 calendar days.
  - Resolve expedited appeals in 72 hours from receipt.
- Federal regulations allow Plans to extend resolution timeframes for an additional 14 calendar days if conditions are met.

Grievance and Appeal Requirements

- Grievance and appeal log requirements
  1. The date and time grievance or appeal is received;
  2. The name of the beneficiary filing the grievance or appeal;
  3. The name of the staff recording the grievance or appeal;
  4. A description of the complaint or problem;
  5. A description of the action taken by the Plan or provider to investigate and resolve the grievance or appeal;
  6. The proposed resolution by the Plan or provider;
  7. The name of the Plan, provider or staff responsible for resolving the grievance or appeal; and
  8. The date resolution notification sent to the beneficiary.

Grievance and Appeal Requirements

Complaint outcome submissions

- Results of investigations to DHCS by secure, encrypted email to SUDCountyReports@dhcs.ca.gov within 2 business days of completion.

Other submissions

- File complaints about a licensed or certified AOD service provider, registered or certified counselor with Licensing and Certification Division.
  - http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx
- Report suspected Medi-Cal fraud, waste, or abuse to (800)822-6222 or Fraud@dhcs.ca.gov

Grievance and Appeal Requirements

Quarterly report requirements

- Complete the Grievance & Appeal Report template.
- Complete "DMC-ODS County Certification" using the template included with IN 19-022.
  - Must be signed, dated and submitted to DHCS on county letterhead.
- Submit to ODSSubmissions@dhcs.ca.gov.
  - Due dates: October 15th, January 15th, April 15th, and July 15th

NOABD requirements

- IN 18-010E
  - Defines adverse benefit determination
  - Includes required templates
- Plans must use DHCS' uniform notice templates when providing beneficiaries with a written NOABD.
  - An electronic equivalent generated from the Plan's EHR is also acceptable.
- Notifying Providers

NOABD requirements

NOABD must include:

- The adverse benefit determination;
- A clear and concise explanation of the reason for the decision;
- A description of the criteria used; and
- The beneficiary's right access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.
- Applicable "Your Rights" attachment

NOABD requirements

SUBJECT	TIMING REQUIREMENT
Termination, suspension or reduction of previously authorized service	At least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214
Denial of payment	At the time of any action denying the provider's claim.
Denial, delay or modification of all or part of the requested service	Within 2 business days of the decision to the beneficiary. Within 24 hours of making the decision to the affected provider.

Questions?

Provider Directory Requirements

- Make available the following information about its network providers:
  - Provider's name
  - Street address(es)
  - Telephone number(s)
  - Website URL, as appropriate
  - Specialty, as appropriate
  - Accepting new patients
  - Provider's cultural and linguistic capabilities
  - Provider's office/facility has reasonable accommodations
- Shall include the following provider types:
  - Physician, including specialists
  - Hospitals
  - Pharmacies
  - Behavioral health providers

Beneficiary Information Web Posting Requirements

As specified in 42 CFR §438.10, the Contractor shall provide all required information to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.

Quality Management (QM) Program

Intergovernmental Agreement Exhibit A, Attachment I, III, CC

QM Program improves the Plan's established treatment outcomes

- A written description of the QM Program
- Conduct performance-monitoring activities
- Evaluate and update the QM Program annually as necessary

Quality Management (QM) Program

The contractor is responsible for the following:

- Ensure continuity & coordination of care
- Mechanisms to detect underutilization/overutilization of services
- Mechanisms to assess beneficiary/family satisfaction
- Mechanisms to monitor the safety and effectiveness of medication practices
- Mechanisms to monitor appropriate and timely intervention of quality of care concerns
- QM Work Plan

Quality Management (QM) Program

- QM Work Plan:
  - Evidence of the monitoring activities
  - Evidence that QM activities have contributed to meaningful improvement
  - Description of completed and in-process QM activities
  - Description of mechanisms implemented to assess the accessibility of services within its service delivery area
  - Evidence of compliance with the requirements for cultural & linguistic competence

Quality Improvement Committee Requirements

- Does the Plan have a QI Committee established?
  - The Plan shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries.
- What activities is the QI Committee responsible for?
  - Recommend policy decisions;
  - Review and evaluate the results of QI activities
- How often does the QI Committee meet?
  - QI Committee shall review data at a minimum on a quarterly basis

Questions?

Overview of CalAIM changes affecting DMC-ODS for next 6 years

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

- https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

Behavioral Health CalAIM Initiatives Affecting DMC-ODS

- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvement
- Behavioral Health Regional Contracting
- Administrative Integration of Behavioral Health services
- Behavioral Health Payment Reform

DMC-ODS Program Renewal and Policy Improvements

New County onboarding in sync with Payment Reform in 2022

- CalAIM Proposal Goals:
- To clarify or change DMC-ODS policies to improve beneficiary experience, increase administrative efficiency, ensure cost-effectiveness and achieve positive beneficiary health outcomes, and encourage new counties to opt in to DMC-ODS.

DMC-ODS Program Renewal and Policy Improvements

- DHCS proposes to update the DMC-ODS program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.
- This initiative is in active planning stage to identify, track, and develop potential policy changes.
- DMC-ODS will be moved from 1115 waiver to 1915(b) waiver ending demonstration status
- A county survey with DMC-State Plan counties conducted to identify counties may be interested in opting-in to DMC-ODS as independent county. Currently providing Technical Assistant Webinars to establish DMC-ODS onboarding plan.

DMC-ODS Program Renewal and Policy Improvements

- One year renewal for 2021 – includes some policy improvements (e.g., updates for residential treatment, medications for addiction, recovery services, and others)
- Engaging with new counties
  - 10 of 21 DMC state plan counties interested in participating
  - Prep work for regional contracting across BH

Regional Contracting

New DMC-ODS county onboarding in sync with Payment Reform in 2022

- CalAIM Proposal Goals:
- Encourage counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries.

Regional Contracting

- Initial focus is encouraging counties that don't currently participate in DMC-ODS to participate through regional approaches.
- A county survey with DMC-State Plan counties conducted to identify counties may be interested in Regional DMC-ODS approach
- A county survey with DMC-State Plan counties conducted to identify counties may be interested in opting-in to DMC-ODS as regional plan. Currently providing Technical Assistant Webinars to establish DMC-ODS onboarding plan.
- Continue with stakeholder engagement for other regional contracting opportunities.

Administrative Integration

2027

- CalAIM Proposal Goals:
- Improve outcomes for beneficiaries and reduce administrative and fiscal burdens for counties, providers, and DHCS by integrating the administration of specialty mental health and SUD services into one behavioral health managed care program starting in 2027.

Administrative Integration (Cont.)

- This is a multi year initiative with goal to implement in 2027.
- Initiative is in very early initial development. Over a series of planning and design sessions, DHCS will further develop the approach and detailed work plan for this initiative.
- Ensuring alignment with other CalAIM initiatives, e.g. Documentation Redesign, Payment Reform etc.
- Goal is to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal.

Specific Areas of Focus in Administrative Integration

Clinical Integration

- Access line
- Intake/Screening/Referrals
- Assessment
- Treatment Planning
- Beneficiary Informing Materials

Administrative Integration

- Contracts
- Data Sharing/Privacy Concerns
- Electronic Health Record Integration and Re-Design
- Cultural Competence Plans

DHCS Oversight Functions

- Quality Improvement
- External Quality Review Organizations
- Compliance Reviews
- Network Adequacy
- Licensing & Certification

Documentation Reform

January 2022

Static Treatment Plan	→	Dynamic Problem List
Uncoordinated Assessments	→	Domain-driven Assessments
Complex and Lengthy Narrative Notes	→	Lean Documentation
Disallowances for Quality	→	Disallowances for Fraud, Waste, Abuse; CAPs for QI

Payment Reform

July 2022

- Partnering with Local Government Financing Division
- Shifting from cost-based reimbursement to fee for service – building foundation for payment on quality
- Updating billing codes
- Peer grouping for rate setting

Payment Reform (Cont.)

- CalAIM Proposal Goals:
- Reform behavioral health payment methodologies with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives.
- Move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from Medicaid Certified Public Expenditure (CPE)-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share.

Payment Reform (Cont.)

- Transition from a cost-based approach (interim payment, CPE, reconciliation) to a value-based intergovernmental transfer approach to reduce administrative burdens and increase flexibility.
- Currently working on the code transition, rate setting, other changes needed in achieving broader payment reform goals.
- Program team is engaging closely with the systems team to ensure systems readiness.
- Continue stakeholder engagement.

Questions?

- Please send unanswered questions to your assigned liaisons or CountySupport@dhcs.ca.gov