NHELP – National Health Law Program Mental Health Services: Medi-Cal Manage Care Rights

Kim Lewis – April 12, 2018 – Patients' Rights Advocacy Training

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NATIONAL HEALTH LAW PROGRAM

National public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.
Washington D.C., Los Angeles & North Carolina
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What We will cover…

Medi-Cal Covered Mental Health Services

1. Delivery Systems
2. Specialty Mental Health Services
    - Services covered
    - Other criteria
3. Plan Responsibilities
4. Recent Changes to Managed Care
    - Timely Access Standards
    - Grievances and Appeals

Question and Answer

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MEDI-CAL DELIVERY SYSTEMS

Fee-for-service v. Managed care

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Voluntary v. Mandatory Managed Care

- "Mandatory" enrollees in managed care
  - * Families, childless adults, people with disabilities, aged
- "Voluntary" enrollees
  - * Foster youth in most counties
    - Not COHS
- Some ineligible for managed care
  - * Share of cost

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MEDI-CAL MANAGED CARE

Types of Plans

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County Organized Health System

- COHS serves about ~ 2.2M beneficiaries through six health plans in 22 counties
  - * *Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo*
- DHCS contracts with a single health plan created by the County
- Plans not Knox-Keene licensed (except HPSM);
  - * i.e. not regulated by Dept. of Managed Health Care

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Geographic Managed Care

- GMC serves ~ 1.1M beneficiaries in two counties
    - * Sacramento and San Diego
- DHCS contracts with several commercial plans - more choices for the beneficiaries
- All GMC plans are Knox-Keene licensed

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Two-Plan Model

- Two-Plan serves ~ 6.9M in beneficiaries in 14 counties
    - * Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare
- One Local Initiative (county organized) and one Commercial Plan - DHCS contracts with both
- All are Knox-Keene licensed

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Regional Model

- Content Regional serves ~ 300K beneficiaries in 18 counties
    - * Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba
- two Commercial Plans that contract with DHCS
- All are Knox-Keene licensed

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Other County Models

- Imperial Model. This plan serves ~ 75K in Imperial County where DHCS contracts with two commercial plans

- San Benito (Voluntary) Model. This plan serves ~ 8K in San Benito County where DHCS contracts with one commercial plan

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MEDI-CAL MENTAL HEALTH MANAGED CARE

The "Carve Out" Delivery System

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1915(b) Specialty Mental Health Services (SMHS) Waiver

- Consolidated the Psychiatric Inpatient Hospital services provided through the fee-for-service (FFS) delivery system and the Short-Doyle/Medi-Cal system (SD/MC)
    * County mental health departments became responsible for both FFS and SD/MC psychiatric hospital systems for the first time
- All Medi-Cal beneficiaries must receive SMHS through the county: The 1915(b) Medicaid waiver – takes away "freedom of choice" for the beneficiary
- This resulted in the risk for this entitlement program shifting from the state to the counties – "*Realignment*"

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1915(b) SMHS Waiver

- The State Plan and the Waiver is California's agreement between Centers for Medicare and Medicaid Services (CMS) and DHCS for the administration of the SMHS under the Medi-Cal program
    * http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx
- Under the waiver, 56 local county mental health plans (MHPs) are responsible for the local administration and provision of Medi-Cal SMHS
    * directly and/or through a network of contractors
    * Current SMHS waiver term: July 1, 2015 - June 30, 2020

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SMHS Funding/Reimbursement

- MHPs are reimbursed a percentage of their actual expenditures (Certified Public Expenditures-CPE) based on the Federal Medical Assistance Percentage (FMAP)

    * Same for all SMHS except FFS/MC inpatient hospital services
    * 1915(b) Waiver limits reimbursement to an Upper Payment Limit (UPL) for each MHP based on actual CPE incurred by MHP
- County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
- County MHPs and DHCS reconcile the interim amounts to actual expenditures through the year end *cost report settlement* process
- DHCS audits the cost reports to determine final Medi-Cal entitlement

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Who regulates the various Medi-Cal plans?

- DHCS regulates the following:
    * Other COHS and PCCMs
    * County Mental Health Plans
    * Denti-Cal Plans
    * 2Plan, GMC, RM, SB, IM Plans + HPSM.
- DMHC regulates the following:
    * Denti-Cal Plans
    * 2Plan, GMC, RM, SB, IM Plans + HPSM.

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SPECIALTY MENTAL HEALTH SERVICES

Covered Services

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Specialty Mental Health Services

Cal Code of Regulations, title 9, Statute 1810.247

Outpatient Services

- Mental Health Services (assessment, plan development, therapy, rehabilitation and collateral)
- Medication Support Services
- Day Treatment Intensive
- Day rehabilitation
- Crisis Residential
- Crisis Intervention

- Crisis Stabilization
- Adult Residential Tx
- Targeted Case Management
- EPSDT services

Inpatient Services

- Acute psychiatric inpatient hospital services
- Psychiatric Inpatient Hospital Professional Services (if the beneficiary is in a fee-for-service hospital)
- Psychiatric Health Facility Services

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Access to Specialty Mental Health Services (SMHS)

- Have an included mental health diagnosis
- Must meet medical necessity criteria
  - and must meet specific impairment and intervention criteria
- Different impairment and intervention criteria for adults and children
  - Adults must have a significant level of impairment
  - Children can have any impairment level

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SMHS - Included Diagnoses

(A) Pervasive Developmental Disorders, except Autistic Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy and Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood, or Adolescence
(F) Schizophrenia and other Psychotic Disorders, except those due to a General Medical Condition
(G) Mood Disorders, except those due to a General Medical Condition
(H) Anxiety Disorders, except those due to a General Medical Condition
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilias
(M) Gender Identity Disorder
(N) Eating Disorders
(O) Impulse Control Disorders Not Elsewhere Classified
(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses.

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MHP is not responsible - Excluded Diagnoses

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorders (Other Pervasive Developmental Disorders are
- included)
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder

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Early & Periodic Screening, Diagnosis, & Treatment (EPSDT)

- Mandatory service for Medi-Cal eligible children and youth up to age 21

- State or MCPs have to screen all children
- Covers ALL treatment necessary to "*correct or ameliorate physical and mental illnesses and conditions*," even if service not covered under the state plan

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Children must meet all the following:

- Included Diagnosis
- Condition not responsive to physical health care treatment
- Meet medical necessity
    * necessary to "*correct or ameliorate*" the condition

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MCP AND MHP RESPONSIBILITIES

Service Coordination

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Mental Health Services Added to MCPs in 2014

- Mental health services included in the essential health benefits package adopted by the State
  - * Part of the Affordable Care Act (ACA)
- MCPs must provide mental health benefits covered in the state plan, excluding benefits provided by MHPs under the SMHS Waiver
  - * To all managed care enrollees

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf

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Medi-Cal Mental Health and Substance Use Disorder Services (MHSUDS) Delivery Systems

Target Populations and Services:

- Medi-Cal Managed Care Plans (MCP)
  - * Target Population: Children and adults eligible for outpatient non-specialty mental health services (adults: mild to moderate conditions)
    - Non-Specialty Mental Health Services Carved-in Effective 1/1/14
      - * Mental Health Services
        - Individual and group mental health evaluation and treatment (psychotherapy)
        - Psychological testing when clinically indicated to evaluate a mental health condition
        - Outpatient services for monitoring drug therapy
        - Outpatient laboratory, medications, supplies, and supplements
        - Psychiatric consultation
      - * Alcohol Abuse Services
        - Screening, Brief Intervention, and Referral to Treatment
- County Mental Health Plan (MHP)

- Target Population: Children and adults with disabling conditions that require mental health treatment (children; adults w/ severe cond.)
    - Medi-Cal Specialty Mental Health Services
        - Outpatient Services
            - Mental Health Services (assessments, plan development, therapy, rehabilitation and collateral, medication support)
            - Day Treatment services and rehabilitation
            - Crisis intervention and stabilization
            - Targeted Case Management
            - EPSDT specialty mental health services
        - Inpatient Services
            - Acute psychiatric inpatient hospital services
            - Psychiatric Health Facility services
            - Psychiatric Inpatient Hospital Professional Services if the beneficiary is in a FFS hospital

Source: DHCS

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MCP Responsibilities

- Screening
- Assessment of needs
- Referral to MHP
- Care Management
    - Physical and mental health
- Coordination of medically necessary care
    - in and outside the network
- Memorandums of Understanding with the MHP

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Screening and Referral Pathways

Primary Care Provider

- Health Risk Assessment
- Screening

MCP's Mental Health Provider

- Health Risk Assessment

- Screening
    - * A greed upon with MHP

MHP's Specialty Mental Health Provider

- Assessment
    - * Agreed upon with MCP

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Memorandum of Understanding (MOU)

Objectives

- Ensure coordination between the managed care plans and specialty mental health plans
- Promote local flexibility that exists at the county level

Core Elements

- Basic Requirements
- Covered Services and Populations
- Oversight Responsibilities of the MCP and MHP
- Screening, Assessment, and Referral
- Care Coordination
- Information Exchange
- Reporting and Quality Improvement Requirements
- Dispute Resolution
- After-Hours Policies and Procedures
- Member and Provider Education

Source: DHCS

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DHCS Guidance: MCP All Plan Letters (APLs)

- Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services (Supersedes APL 13-021): APL 17-018
- Dispute Resolution Process for Mental Health Services: APL 15-007
- Physical Health Care Covered Services Provided for Members Who Are Admitted to Inpatient Psychiatric Facilities: APL 15-015
- Requirements for coverage of EPSDT Services for Medi-Cal Beneficiaries under Age 21: APL 14-017
- All Plan Letters DHCS website: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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DHCS Guidance: MHSUDS Information Notices and Resources

- MHSUDS Information Notice 14-020 (describes outpatient Medi-Cal mental health services covered by MCPs and Fee-for-Service Medi-Cal
- MHSUDS Information Notice 15-015 (provides guidance to MHPs on how to submit a MHP/MCP service delivery dispute that cannot be resolved at the local level to the Department of Health Care Services (DHCS)
- MHSUDS Stakeholder Information Website (provides links to various activities and information related to the planning, delivery and monitoring of MHSUD services): http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD_Partners-Stakeholders.aspx
- MHSUDS Stakeholder Information e-mail (stakeholders may use this email to submit MHSUDS-related comments, concerns, or questions): MHSUDStakeholderInput@dhcs.ca.gov

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RECENT Changes to Managed Care

1. Timely Access Standards
2. Due Process (Grievances and Appeals)

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Medicaid Managed Care Rules

- Federal Managed Care Regulations – Part 438 of title 42 Code of Federal Regulations
- Final rule issued May 6, 2016
    - Effective date of Final Rule was July 5, 2016
- Phased implementation of new provisions over a 3 year period
    - Network Adequacy (Access Standards): July 1, 2018
    - Grievances and Appeals: July 1, 2017
- Rules apply to PIHPs (= MHPs) and align with MCOs (=MCPs)

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Access to Care Standards

Time and distance standards
Timely access to appointments

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Time and Distance Standards – Mental Health Services – July 1, 2018

Standards vary by county size:

- (Rural): 60 miles/ 90 minutes from beneficiary's residence
    * Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne
- (Small): 45 miles / 75 minutes from beneficiary's residence
    * Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
- (Medium): 30 miles / 60 minutes from beneficiary's residence
    * Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
- (Large): 15 miles / 30 minutes from beneficiary's residence
    * Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara

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Timely Access to Appointments

- Urgent care appointments that do not require prior authorization
    - Standard access to appointment: 48 hours
- Urgent care appointments that do require prior authorization
    - Standard access to appointment: 96 hours
- Non-urgent primary care appointments
    - Standard access to appointment: 10 business days
- Non-urgent specialist (Psychiatry)
    - Standard access to appointment: 15 business days
- Non-urgent mental health provider (non-psychiatry)
    - Standard access to appointment: 10 business days

- Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health conditions
    - Standard access to appointment: 15 business days
- Telephone wait time
    - Standard access to appointment: No more than 10 minutes
- Normal business hours
    - Standards
- Triage – 24/7 services
    - Standard access to appointment: 24/7 services; Call back time is no more than 30 minutes

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Timely Access - Limited Exceptions

Extended Appointments

- If referring or treating provider has determined a longer wait time will not have a detrimental impact on the health of the beneficiary*
- Must be noted in the beneficiary's record

Periodic Office Appointments

- Visits to monitor and treat mental health conditions may be scheduled in advance*

* consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice

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Network Adequacy Guidance to MCPs /MHPs

- DHCS Final Network Adequacy Standards: http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf
- AB 205 (Wood)
- APL 18-005 (2/16/18)
- MHSUDS Information Notice 18-011 (released 2/13/18)

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Grievance and Appeals

Notice and the Right to a Hearing in Medi-Cal

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Medicaid Due Process: Legal Authority

- 14th Amd., U.S. Const.
- 42 U.S.C. statute 1396a(a)(3)
- 42 U.S.C. statute 1396u-2(b)(4)
- 42 C.F.R. pts. 431, 438 pt E (MC)
- Welf. & Instit. Code statute 14197.3
    - (Added by Stats. 2017, Ch. 738, Sec. 7. (AB 205) Effective January 1, 2018.)

DUE PROCESS = NOTICE & OPPORTUNITY TO BE HEARD

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Grievance and Appeal Systems

- MHP must have a grievance and appeal system that meets the requirements of federal regulations
- State must conduct random reviews of each MHP and its providers/subcontractors to ensure they are notifying enrollees in a timely manner

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Handling of Grievances and Appeals

- Plan must give reasonable assistance
    - completing forms
    - procedural steps related to a grievance or appeal
- Includes auxiliary aids and services
    - providing interpreter services
    - toll free numbers
    - adequate TTY/TTD and interpreter capability

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Plan Recordkeeping

- Must maintain records of grievances and appeals

- State must review them as part of ongoing monitoring
- Record of each grievance or appeal must contain all of the following:
    * General description of the reason for appeal or grievance
    * Date received
    * Date of each review
    * Resolution at each level of the appeal or grievance
    * Name of beneficiary for whom appeal or grievance was filed
- Records must be maintained in a manner accessible to state (and available upon request to CMS)

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Appeals

Action = *Adverse Benefit Determination* =

- Denial, reduction, suspension, termination, delay of service
- Denial/limited approval based on medical necessity, appropriateness, type, level, setting or effectiveness
- Disputes involving cost sharing
- Failure to act within timeframe for standard grievances

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Terminations, Reductions, Suspensions of an existing service

- Plan decides to termination, reduce, or suspend a service that someone is already receiving
- Includes situations where a person is receiving a service, and requests reauthorization of the same service

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Grievance

- An expression of dissatisfaction about any matter other than an *adverse benefit determination*

- Can be filed *any time*
- Oral or written
- Resolution: w/i 90 calendar days of MC receipt

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Notice of Adverse Benefit Determination – Timing

- Terminations, Reductions, Suspensions: plan must provide notice at least 10 days in advance of the decision effect date
- Denial, delay, or modification of all or part of the requested specialty mental health service request: within 2 business days of decision /as expeditiously as condition requires (not to exceed 14 days) (APL 17-006; MHSUDS IN 18-010)
- Denial of payment, at the time of any action denying the provider's claim

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Contents of the Notice

- Statement of the action the plan intends to take
- Clear and concise explanation of the reasons for the decision
  - If based on medical necessity, the notice must include the clinical reasons for the decision
  - Explicitly state why the beneficiary's condition does not meet specialty mental health services and/or medical necessity criteria
- Description of the criteria or guidelines used
  - This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations
- Right to be provided (upon request and free of charge) reasonable access to and copies of all documents, records, and other information relevant to the ABD

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Model NOABDs required

- Denial of authorization for requested services
- Denial of payment for a service rendered by provider.
- Delivery system (MCP v MHP)

    * determination that beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan
- Modification of requested services Use this template
- Termination of a previously authorized service
- Delay in processing authorization of services
- Failure to provide timely access to services
- Dispute of financial liability

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Process to Appeal Adverse Benefit Determinations

- Step 1: Notice of ABD
- Step 2: Plan Internal Appeal
- Step 2a: Two Options
    * DMHC Complaint Not MHPs or
    * IMR Not MHPs
- Step 3: State Fair Hearing

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Step 1: Internal Plan Review

Appeal

- Review of an Adverse Benefit Determination
- Must request *within 60 days of notice*

Note: Grievance

Expression of dissatisfaction about any matter not an adverse benefit determination

- Can request at any time

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Benefits Continuing Pending Appeal

- Only available for cases involving a termination, reduction, or suspension of service
- Must request continuing benefits within 10 days of the notice date ***or*** before the proposed change
- Benefits continue until appeal is resolved favorably (may request again at fair hearing stage)

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Expedited Internal Plan Review

- Available when provider indicates (or the plan determines) that standard timeframe may *seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function*
- Plan must resolve expedited appeal within 72 hours

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Internal Review Process Requirements

Plans must:

- Ensure that decision-maker:
    1. has the ability to require corrective action,
    2. was not involved in any prior decisions on the case, and
    3. has appropriate clinical expertise in treating condition
- Provide enrollee the opportunity to present evidence, and allegations in person and in writing
- Allow the enrollee (or her representative) to examine any case records
- Resolve grievances and appeals within time required by enrollees health condition - generally no more than 30 days

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Notice of Appeals Resolution (NAR)

- When Adverse Benefit Determination or other plan decision is upheld or not resolved 100% in the enrollee's favor
- Timeframe for resolution
    * Standard cases: 30 days
    * Expedited cases: 72 hours
    * Time may be extended by 14 days if requested by beneficiary or delay is in beneficiary's interest
        - provide written notice of the extension within two calendar days

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NAR Content

- If Adverse Benefit Determination is upheld:
    * Result of the appeal and the date of decision

        * Criteria, clinical guidelines or policies used
        * Explanation that:
            - Enrollee also has the right to a Medi-Cal fair hearing
            - Enrollee has the right to continue benefits, and how to do so
- If Adverse Benefit Determination is overturned:
    * clear and concise explanation of the reason

Note: plan must authorize or provide the disputed services promptly (*no longer than 72 hours*)

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Step 2: External Review

- When Can It Be Requested
    * When Adverse Benefit Determination or other plan decision is upheld or not resolved 100% in the enrollee's favor
- What You Get: State Fair Hearing
    * For cases involving adverse benefit determinations, must file for hearing *within 120 days of the NAR*
    * For grievances that are not an adverse benefit determination, generally must file within *90 days of the event* at issue (including time spent in grievance)

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External Review: Exhaustion

- Consumers generally must exhaust the plan's internal review process before they can proceed to external review
    * NOTE: it's not clear if you must exhaust the appeal process for issues that do not involve an adverse benefit determination
    * *Deemed exhaustion*: when plan fails to provide adequate notice or follow grievance/appeal rules, or does not resolve grievance/appeal within 30 days
    * Exception: urgent cases

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Expedited Review

- When Eligible for Expedited Review

        * When standard timeframe may seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function
- Timeframe: State Fair Hearing
    * resolve *within 3 business days of request*, or quicker if required by the enrollee's health condition

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What is a State Fair Hearing?

- Review by an Administrative Law Judge employed by the state
- Available to review any action or inaction by state or its agents related to Medi-Cal eligibility or benefits, such as:
    * Denial of benefits/failure to act with reasonable promptness
    * Reduction, suspension, termination of service
    * Transfer or discharge from SNF
- But Not: if *sole* issue is federal or state law and:
    * Enrollee does not question that the law has been correctly applied
    * A change in the law requires a reduction in Medi-Cal benefits

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Resolution at State Fair Hearing

- Standard cases: A decision within 90 days of request
- Expedited cases: Within 3 business days, or quicker if required by the enrollee's health condition
- Plan must implement the decision within 72 hours, or quicker if required by the enrollee's health condition

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Mental Health Plan Appeal

Diagram with 3 boxes with arrows between them pointing towards another box.
Box 1 has an arrow pointing towards box 2 and reads:

- Adverse Benefit Determination (Individual has up to 60 calendar days from date on notice to file)
    * Notice must be provided at least 10 days prior to action
    * Enrollee has up to 10 days to request continued benefits

Box 2 has an arrow pointing towards box 3 and reads:

- Plan Internal Appeal

  * Decision w/i 30 calendar days after plan receives appeal
  * Only one level permitted

Box 3 has an arrow pointing at it coming from box 1 with an “X” over the arrow and reads:

- State Fair Hearing (Individual has up to 120 days to request fair hearing after plan decision)
  * Decision w/i 90 days post filing
  * “Deemed exhaustion”

No State option for direct path to SFH w/o in-plan exhaustion

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After State Fair Hearing Resolution

- *Rehearing* is available at the state’s discretion
  * Must request *within 30 days* of hearing decision
- Go to state or federal court
- NOTE: DHCS Director must adopt or alternate *proposed decision* by DSS ALJ

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Grievances and Appeals review

- Right to file a grievance
  * Complaint re quality of services or other issues
- Right to file an appeal
  * Any *Adverse Benefits Determination*
  * Right to a “state fair hearing”
    - Must appeal to plan before can get a hearing
- Need help?
  * Health Consumer Alliance: (888) 804-3536
  * www.healthconsumer.org

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Grievance & Appeals – Resource & DHCS Guidance to MCPs and MHPs

- AB 205 (Wood) - Welf. & Instit. Code § 14197.3
- APL 17-006 (released 5/9/17)
- MHSUDS Information Notice 18-010 (released 2/14/18)

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Parity In Mental Health & SUD services

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CA Parity Requirements

- March 29, 2016, CMS issued the Medicaid Mental Health Parity Final Rule (Parity Rule)
  - applies to Medicaid MCOs
  - inpatient, outpatient, emergency care and prescription drugs
- Parity Between MH/SUDS and medical / surgical services
- Parity includes:
  - Aggregate lifetime and annual dollar limits
  - Financial requirements (FR) such as copayments, coinsurance, deductibles, and out-of-pocket maximums
  - Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits
  - Non-quantitative treatment limitations (NQTLs), such as limits on the scope/ duration of benefits in processes, strategies, and evidentiary standards, or other factors, such as medical management standards

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DHCS Parity Compliance Plan: MCPs/MHPs

- Contract Alignment
- Quantitative Treatment Limits (QTL)
- Non-Quantitative Treatment Limits (NQTL)
  - Network Adequacy
  - Grievances and Appeals
  - Authorization process and timeframes for SMHS ~ 7/2018
  - Continuity of Care ~7/2018

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Parity Resources

- October 2, 2017 Compliance Plan submitted to CMS http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx

- October 2, 2017 Compliance Plan submitted to CMS
  http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx

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Questions?

Feel free to contact me with any questions. This is my contact information:

- Name: Kim Lewis
- Title: Managing Attorney
- Organization: National Health Law Program
- Email: lewis@healthlaw.org

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Thank You

NHeLP website: www.healthlaw.org
NHeLP Offices:

- Washington DC
    * Address: 1444 I Street NW, Suite 1105, Washington, DC 20005
    * Phone: (202) 289-7661
    * Fax: (202) 289-7724
    * Email: nhelpdc@healthlaw.org
- Los Angeles
    * Address: 3701 Wilshire Blvd, Suite #750, Los Angeles, CA 90010
    * Phone: (310) 204-6010
    * Fax: (213) 368-0774
    * Email: nhelp@healthlaw.org
- North Carolina
    * Address: 200 N. Greensboro St., Suite D-13, Carrboro, NC 27510
    * Phone: (919) 968-6308
    * Fax: (919) 968-8855
    * Email: nhelpnc@healthlaw.org