

HEALTH PLAN COMMENTS ON 2011-12 HFP MODEL CONTRACT

Section		Page	Type of Change	Comments	Comments from Health Plans	MRIMIB Staff Recommendations
I. Introduction	C.2. Geographic Areas Covered	2	Substantive	<ul style="list-style-type: none"> Adds language that if the change in geographic coverage area is to withdraw due to a plan initiated change, the Contractor shall request such approval at least 90 days prior to the date the change will take place. 	<p>Plan Recommendation(s):</p> <ul style="list-style-type: none"> Include language to state if the State does not provide final rates to Contractor at least (ninety) 90 days in advance, then Contractor shall have an additional five (5) working days to review rates. 	Delete proposed language and replace with a statement that the plan will not make any changes to its coverage areas within the first ninety (90) days of the benefit year.
II. Enrollment	K.5. Network Information Services	10	Substantive	<ul style="list-style-type: none"> Adds language requiring the Contractor to promptly notify the State of any providers that have been debarred, suspended, proposed for debarment, or declared ineligible or voluntarily excluded from participation in any federally-funded health care program. 	<ul style="list-style-type: none"> Duplicate process for all plans to report on same disbarred providers. Information already publicly available to the State. 	Delete proposed language.
					<p>Plan Recommendation(s)</p> <ul style="list-style-type: none"> Language should be deleted or be consistent with Medi-Cal's contract language. Prohibit the Plan from employing any person listed on the Medi-Cal list of suspended/debarred providers on the Medi-Cal website. 	

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III. Customer Service	B.2. Grievance Procedure for Department of Managed Health Care Licensees and Department of Insurance Licensees	13	Substantive	<ul style="list-style-type: none"> Adds grievances related to mental health services, substance abuse treatment services, and prescription drugs as specific reporting categories. 	<ul style="list-style-type: none"> Grievance tracking system may not allow reporting on type of service and subject. 	No change to proposed language.
IV. Covered Services and Benefits	B.1. California Children's Services (CCS)	18	Substantive	<ul style="list-style-type: none"> Clarifies that medically necessary services authorized and provided under CCS are not covered services under this Agreement. 	<ul style="list-style-type: none"> There will be an increase in rates from cost-shifting these services to the plans. There is no mechanism available to the plan to account for additional expensive care. Counties will continue to delay providing services. 	No changes to proposed language.
IV. Covered Services and Benefits	B.8. California Children's Services (CCS)	19	Substantive	<ul style="list-style-type: none"> Clarifies the Contractor's responsibility once the CCS program is providing services. 	<ul style="list-style-type: none"> Shifts responsibility for CCS costs and care jeopardizes Plan participation. Adds additional costs that will increase rates. 	No changes to proposed language.
					<p>Plan Recommendation(s)</p> <ul style="list-style-type: none"> Delete requirement. Eliminate carve-out and build in cost of coverage in the plan rates. There is no responsibility placed on the CCS program to ensure services are provided. 	

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					<ul style="list-style-type: none"> Consider reimbursing plans for these services by: <ol style="list-style-type: none"> 1)requiring plans to report CCS-related costs in their Rate Development Templates (RDTs), or 2)require plans to separately report cost data for CCS services. Review MOU timeframes for consistency in all counties. 	
IV. Covered Services and Benefits	B.9. California Children’s Services (CCS)	19	Substantive	<ul style="list-style-type: none"> Clarifies the Contractor’s responsibility to provide all medically necessary covered services to treat the CCS condition in the event the CCS Program does not provide the services needed. 	<p>Plan Recommendations</p> <ul style="list-style-type: none"> Specify services that plan are expected to cover and establish method of reimbursement. CCS must work with plans to establish clear guidelines on eligibility determination. Eliminate carve-out and fully reimburse the plans. 	Delete proposed language.
V. Covered Services and Benefits	C.2. Mental Health and Substance Abuse Services	20	Substantive	<ul style="list-style-type: none"> Adds a new section requiring the Contractor to develop and submit a plan and timeframe as to how Contractor will support parents of children with mental health and substance abuse conditions and outlines the elements the plan should include. 	<ul style="list-style-type: none"> Role of plan is to educate members about the availability of services. Much of the specified information is already available in the Evidence of Coverage (EOC). Use proposed language requiring Contractor to develop informational materials regarding mental health and substance abuse services 	Change the term “support” to “educate” and indicate that the elements <u>may</u> be included in the plan’s proposed activities to educate parents and guardians about mental health and substance abuse treatment services.

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					<ul style="list-style-type: none"> Provide Plans with model language and guidance. 	
V. Covered Services and Benefits (continued)	C.3. Mental Health and Substance Abuse Services	20	Substantive	<ul style="list-style-type: none"> Requires Contractor to track and report the length of time from the date a subscriber was referred for plan-provided mental health services to the actual date mental health services were provided to the subscriber. 	<ul style="list-style-type: none"> Places the plan between the Mental Health providers and members. Plans do not have data available as there is no tracking or reporting currently required from counties to plan. Would require preauthorization of services thereby creating an additional barrier for members to access services. Can only report on the number of referrals that mental agency receives. 	No change to proposed language.
IV. Covered Services and Benefits	D.3. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	22	Substantive	<ul style="list-style-type: none"> Requires Contractor to conform its policies and procedures "as defined in the MOU." 	<ul style="list-style-type: none"> Request MOU for review prior to finalizing contract. 	Delete references to the MOU.

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IV. Covered Services and Benefits	D.4. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	22	Substantive	<ul style="list-style-type: none"> Requires the Contractor to notify the State of the mental health screening tools used and report on the number of subscribers screened for mental health conditions. Changes the timeframe for reporting from October to February. 	<ul style="list-style-type: none"> Physicians do not report to plans which screening tool they use. Plans do not have specified data. There is no universal screening tool used by all providers. Not able to report using screening tools specified. Reporting will be time consuming, and burdensome on administrative costs. 	Delete proposed language that requires the plan notify the state of the screening tools and number of subscribers screened.
					Plan Recommendation(s)	
					<ul style="list-style-type: none"> Delete proposed language. 	
IV. Covered Services and Benefits	D.6.e. Mental Health: Services for Subscriber Children with SED or SMD	23	Substantive	<ul style="list-style-type: none"> Requires the Contractor to coordinate inpatient care with county mental health departments. 	<ul style="list-style-type: none"> MRMIB requested to provide a list of county contacts. 	Delete proposed language.
IV. Covered Services and Benefits	D.7. Mental Health	23	Substantive	The Contractor is not responsible to provide services that are authorized and provided by the county mental health department.	<ul style="list-style-type: none"> Imposes another cost shift. Plans should be reimbursed for these services. 	No change to proposed language.
					Plan Recommendation(s)	
					<ul style="list-style-type: none"> Delete language. 	

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IV. Covered Services and Benefits	H.3 Copayments	24-25	Substantive	<ul style="list-style-type: none"> Requires the Contractor to report all copayments paid by subscriber households for covered services in the previous benefit year, not just those who reached the \$250 maximum. 	<ul style="list-style-type: none"> Creates excessive administrative burden for plans as this data is contained in multiple places. 	Delete requirement to report all copayments. Return to current reporting requirement.
IV. Covered Services and Benefits	H.5 Copayments	25	Substantive	<ul style="list-style-type: none"> Requires plans to monitor copayments on a quarterly basis. 	<ul style="list-style-type: none"> Continue to require members to track their copays Plans could send a reminder notification on copayment maximum and their reporting responsibility in mid-year. Increase publicity in HFP handbook and other member materials. 	Delete quarterly monitoring requirement. Revise language requiring the plan to notify families in the third (3 rd) quarter of the benefit year of the copayment maximum and the process for informing the plan when the family reaches the annual copay maximum.

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IV. Covered Services and Benefits	H.6 Copayments	25	Substantive	<ul style="list-style-type: none"> Requires the Contractor to inform its providers to stop collecting copayments when a subscriber household reaches the \$250 family copayment maximum in a benefit year. Requires the Contractor to reimburse the subscriber household the amount exceeding \$250 within 90 days of Contractor's determination that an overpayment occurred. Requires Contractor not to rely solely on the subscriber household to notify Contractor when the subscriber household reaches the \$250 copayment maximum. 	<ul style="list-style-type: none"> No current tracking system for payment of copays. Plan would not be aware of which providers the member may see in the future Under Knox-Keene Act, contractors must be allowed 90 days to submit claims and non-contracted providers are afforded at least 180 days. This would create a significant delay in tracking copayments. Capitated plans would have to use encounter data to track copays and the data is not submitted to the plans for 60-90 days after date of service. This would create a significant delay in tracking copayments Changes the longstanding HFP policy that requires subscribers to notify the plan when the maximum copay is reached. Plans do not know if families actually paid the copayments. Many HFP families do not have bank accounts and also move frequently. Plans would be disbursing checks that cannot be cashed. Significant administrative costs to plans to send these checks 	<p>Add language requiring plans to reimburse excess copayments when a subscriber family provides information that the family has reached the copayment maximum.</p> <p>Delete language requiring plans to not rely solely on the subscribers to notify when copay maximum is reached.</p>

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IV. Covered Services and Benefits (continued)	H.7 Copayments (continued)	25			Plan Recommendation(s)	
					<ul style="list-style-type: none"> Delete requirement Plans reimburse MRMIB and, through Administrative Vendor, apply credits to future monthly premiums 	
IV. Covered Services and Benefits	I.2. Coordination of Benefits	26	Substantive	<ul style="list-style-type: none"> Requires the Contractor to designate at least one of the Contractor's employees as a Dental Plan Liaison to coordinate benefits and services and resolve issues with a subscriber's dental plan. 	<ul style="list-style-type: none"> Plan member services department is adequate for benefit coordination 	Delete reference to "primary function" and instead make the liaison one of the functions of the designated plan employee.
					Plan Recommendation(s) <ul style="list-style-type: none"> Delete "primary functions" as staff can perform these activities. Amend language to designate liaison to Member Services rather than a specific individual. 	
V. Clinical Quality Measures and Management Practices	A.1. Measuring Clinical Quality	27	Substantive	<ul style="list-style-type: none"> Notifies Contractor that the HEDIS measures may be modified to include core quality measures as required by CMS. 	<ul style="list-style-type: none"> Only use the HEDIS measures contained in Attachment III. 	Delete reference to core quality measures. Maintain current HEDIS reporting requirements.
					Plan Recommendation(s) <ul style="list-style-type: none"> Further discussion on these issues with MRMIB Quality workgroup. 	

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V. Clinical Quality Measures and Management Practices	C.3.a. Health Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to report information on overweight and obese children's Body Mass Index. 	<ul style="list-style-type: none"> Additional costs for reporting requirements. No tracking and reporting mechanism in place; information not captured through encounter or claims data. Requires staff to perform additional activities. reviewing medical charts. Plans would only be able to report this if the State made it a reporting requirement for providers. Would likely have to encourage providers to give information to the plans through a pay for performance mechanism. 	Delete requirement to report on BMI.
V. Clinical Quality Measures and Management Practices	C.3.b. Health Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to increase awareness among its providers of the importance of screening for behavioral health and developmental issues in subscriber children ages 0-5. Requires Contractor to make available to its providers standardized screening tools and lists examples of such tools. 	<ul style="list-style-type: none"> Plans do not provide screening tools. Additional cost to plans. Plans understand intent of section is to increase awareness among providers that certain screening tools are available at a discounted rate and not to require plans to provide screening tools. Screening tools are physician's responsibility. 	Revise language to require plans to inform their providers about the availability of obtaining screening tools at a discount. MRMIB will provide plans with a flyer for distribution to their providers.

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V. Clinical Quality Measures and Management Practices (continued)	C.3.b. Health Care Services (continued)	29			Plan Recommendation(s)	
					<ul style="list-style-type: none"> Delete provision. Revise section to indicate intent is to have plans increase awareness of screening tools. 	
V. Clinical Quality Measures and Management Practices	C.3.c. Health Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to increase awareness among providers of the importance of routine pediatric dental care and encourage pediatricians to educate parents about oral health and the need to visit a dentist for check-ups during well-baby visits. 	<ul style="list-style-type: none"> Physicians can offer health care guidance without plan involvement. 	No change to proposed language.
					Plan Recommendation(s) <ul style="list-style-type: none"> Delete requirement. 	
V. Clinical Quality Measures and Management Practices	D.2. Encounter and Claims Data	30	Substantive	<ul style="list-style-type: none"> Requires the Contractor to provide encounter and claims data no later than 30 days after requested by the State. Requires submission of encounter and claims data no later than 180 days after the end of the month in which a service was rendered. 	<ul style="list-style-type: none"> 30 days is not sufficient time to provide the data. 	Revise language to allow for 60 day timeframe.
					Plan Recommendation(s) <ul style="list-style-type: none"> Revise language to allow for a 60 day turnaround time. 	

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V. Clinical Quality Measures and Management Practices	D.3. Encounter and Claims Data	30	Substantive	<ul style="list-style-type: none"> Requires the Contractor to provide encounter and claims data retroactively to January 1, 2006. 	<ul style="list-style-type: none"> Difficult and costly to go back five years. 	Require retroactive data to 2008.
					Plan Recommendation(s)	
					<ul style="list-style-type: none"> Amend retroactive date to 2008. 	

HEALTH PLAN REQUESTS FOR CONTRACT CHANGES

Section		Page	Type of Change	Comments	Comments from Health Plans	MRMIB Staff Recommendations
Exhibit B			Substantive		<ul style="list-style-type: none"> Add language regarding payment to the Federally Qualified Health Centers (FQHCs) and the Rural Health Centers (RHCs) as required by the Children's Health Insurance Reauthorization Act (CHIPRA). Recommend using language similar to Medi-Cal's plan contracts. 	No change to contract language.
Exhibit B			Substantive		<ul style="list-style-type: none"> Add definition of Medical Loss Ratio to identify what is considered medical versus non-medical. 	No change to contract language.