Department of Behavioral Health
INFORMATION NOTICE 17-10

Date: July 3, 2017

To: All Department of Behavioral Health, Fee-For-Service and Contract Agencies

From: Veronica Kelley, LCSW, Director

Subject: Medicaid Managed Care Final Rule Implementation

Introduction

The purpose of this Information Notice is to communicate the requirements set about by the Centers for Medicare & Medicaid Services (CMS) regarding the Medicaid Managed Care Final Rule and how the Department of Behavioral Health (DBH) plans to implement these requirements. On April 25, 2016, CMS published the Final Rule, which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections.

This Final Rule is the first major update to Medicaid and Children's Health Insurance Program (CHIP) managed care regulations in more than a decade, and is set to be implemented over the next several years with the first significant implementation date on July 1, 2017.

Key Provisions of the Final Rule

There are several key provisions outlined in the Final Rule that will affect current business practices beginning July 1, 2017. In order to fully understand the complete requirements of the Final Rule, reading the entire Rule, located in the Code of Federal Regulations, Title 42 Part 438, is recommended; however, a summary of some of the more important changes is provided below:

- The Final Rule expands Mental Health Plans (MHPs) communication with beneficiaries by mandating specific content, language, and format to be included in the member handbook and provider lists.

- The new grievance and appeal requirements shorten the timeframe from 45 days to **30 days** for standard resolution and from 3 business days to **72 hours** for expedited resolution, as well as limits grievances to only one level for appeals.

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- An important update to the Final Rule mandates MHPs to track requirements related to timeliness of care.
- A written notice of adverse benefit must be provided to the beneficiary immediately after a decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- For standard authorization decisions, MHPs must provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed **14 calendar days** following receipt of the request for service, with a possible extension of up to 14 additional calendar days.

Documentation Updates

In order to meet the requirements laid out by the Final Rule, DBH shall release updated documentation, such as beneficiary informing materials, forms, and policies and procedures, on an on-going basis. When the new documentation is released, please cease all use of old documentation. Communication about the availability of new documentation will occur through email, web blasts, memos and meeting announcements.

Helpful Reference Materials

CMS overhauled 42 CFR Part 438 to address the Final Rule provisions; however, the California Behavioral Health Director's Association (CBHDA) has compiled several helpful resources to better understand the Final Rule requirements:

- Network Adequacy Fact Sheet
- Grievance and Appeals System Fact Sheet
- Beneficiary Informing and Authorization Fact Sheet

Questions

Questions regarding this Information Notice shall be directed to the DBH Quality Management Division at DBH-QualityManagementDivision@dbh.sbcounty.gov or (909) 386-8227.