

**RESPONSE TO THE CALIFORNIA HEALTHCARE  
FOUNDATION'S RECOMMENDATIONS FOR PERFORMANCE  
STANDARDS FOR MEDI-CAL MANAGED CARE  
ORGANIZATIONS SERVING PEOPLE WITH DISABILITIES AND  
CHRONIC CONDITIONS**

**California Department of Health Care Services  
Health Care Programs  
Medi-Cal Managed Care Division**

**Final**

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES**  
**Medi-Cal Managed Care Division**

**EXECUTIVE SUMMARY**

Upon release of the Governor's Budget for Fiscal year 2005-06, the California Department of Health Care Services (DHCS) sought legislative approval to expand Medi-Cal managed care into 13 new counties and implement mandatory enrollment of seniors and persons with disabilities in all models of Medi-Cal managed care. The Department established goals and timelines associated with beginning enrollment of seniors and persons with disabilities as early as September 2006. To address key stakeholder concerns about the managed care program's and plans' readiness to serve this population, the DHCS agreed to develop and implement performance standards appropriate for serving these individuals. The DHCS entered into a partnership with the California Healthcare Foundation (CHCF) to begin this important preparation.

The CHCF released its report entitled "Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions" on November 21, 2005. The CHCF report provides the DHCS with a set of recommendations to enhance existing contract requirements or program administration that would result in improved health care delivery to people with disabilities and chronic conditions. This report is available on the CHCF website at <http://www.chcf.org/topics/medi-cal/perfstandards/index.cfm?itemID=116096>

The CHCF report has 53 recommendations that, if adopted, would result in modification to program processes or creation of new procedures in the DHCS and other state departments, the California Health and Human Services Agency (CHHSA), and at the health plan level, commonly referred to as Managed Care Organizations (MCO). The recommendations in the CHCF report are grouped into eight major categories which address issues specific to the State, MCO contract or MCO operations. The DHCS is supportive of the intent behind the majority of the 53 recommendations provided in the report and offers alternatives for meeting the intent of many of the recommendations. Overall, the DHCS is supportive of 94 percent of the report's recommendations.

**Change from the Original Proposal and Timeline**

The California Legislature approved geographic expansion of Medi-Cal managed care for families and children, but it did not approve mandatory enrollment of seniors and persons with disabilities in managed care counties that have the Two-Plan and Geographic Managed Care models. The DHCS continued its partnership with the CHCF; however, without legislative authority, staffing, and plan funding, it has revised its approach to the recommendations and is releasing a response to the recommendations rather than issuing performance standards as originally envisioned.

## **Cost to Implement Recommendations**

While agreeing with the principle behind most of the recommendations, the potential cost for increased capitation rates to plans, additional staff resources, MCO resources, and system development and enhancements are critical factors that the DHCS must consider before implementation of many of the CHCF recommendations can occur. The DHCS response to the recommendations should not be viewed as a commitment of state funds, and implementation of any recommendations in the CHCF report, or as modified by the DHCS, will be subject to funding availability. The DHCS has not developed funding estimates for the purpose of this response and would utilize the State's priority setting and budget process to pursue any resources necessary for implementation.

## **Overall themes and issues addressed in the CHCF report**

The CHCF report identifies several major themes throughout the eight categories of recommendations to improve delivery of care. An overarching message is the need for the State to develop a statewide provider education plan and strategies to ensure both State and MCO staff become aware of and sensitive to the needs of people with disabilities and chronic conditions. Numerous recommendations address the need for the State to provide MCOs with utilization data both aggregate and stratified specific to the disabled population.

There are recommendations throughout the report that suggest the need to avoid disruption of ongoing care currently provided in the Medi-Cal fee-for-service environment and to better coordinate the special needs of this population. Care coordination is a major theme throughout the report addressing the need for new policies and procedures to ensure availability of providers specializing in the treatment of this population as well as coordination of carve-out services received from other agencies and providers.

Following are brief summaries of findings in each category.

**Cross Cutting Issues (Recommendations 1-10):** These recommendations cut across several categories of the report and include standards on provider education and disability competency, pre-screening of health care needs of new members, and inclusion of disabled members and advocates in planning and policy development. The DHCS agrees with the majority of these recommendations.

**Enrollment and Member Services (Recommendations 11-13):** These recommendations suggest changes to address member transition into managed care; improving Medi-Cal member advocacy; and, providing written materials in alternative formats. The DHCS agrees with the intent of these recommendations and suggests several modifications.

**Network Capacity and Accessibility (Recommendations 14-22):** These recommendations suggest modification to how MCOs assess and inform members about physical access to providers; enhancing accommodation policies; and how the State defines and assesses “accessibility”: The DHCS agrees with most of these recommendations and provides several alternatives for implementation.

**Benefit Management (Recommendations 23-25):** These recommendations relate to the criteria used to determine medically necessary services. The DHCS agrees with the intent of these recommendations, several of which it believes are addressed in current contract language, but will determine which areas may need modification.

**Care Management (Recommendations 26-33):** These recommendations present the vision for care management and distinguish it from case management. Recommendations address the need for a new care management approach and policies specific to disease management programs. The DHCS supports the majority of these recommendations, but they may have significant cost implications.

**Quality Improvement (Recommendations 34-45):** These recommendations include using member data to drive and conduct quality improvement projects specific to people with disabilities and chronic conditions. There are significant personal health information and system issues in sharing data suggested in these recommendations. The DHCS agrees with many of these recommendations or provides alternatives, but will be faced with complex issues on data and confidentiality.

**Performance Measurement (Recommendations 46-50):** These recommendations relate to the collection of data to identify and address clinical and consumer satisfaction issues using Health Employer Data and Information Set (HEDIS) measures, satisfaction surveys and provider incentives. The DHCS will be challenged by a number of these recommendations due to cost and privacy issues.

**Coordination of Carve-Out Services (Recommendations 51-53):** These recommendations specifically require action by the CHHSA and Legislature, and are intended to ensure seamless coordination between MCOs and carve-out service providers. The DHCS agrees with the intent of these recommendations and offers alternatives to address them.

## **Next Steps**

The CHCF recommendations are an excellent resource for the DHCS in its goal to improve access and quality of care for all Medi-Cal beneficiaries, particularly those living with disabilities and chronic health conditions. While there are

challenges in implementing many of the CHCF recommendations, the DHCS intends to work with MCOs and advocates on developing strategies and milestones, and implementing appropriate performance standards in the Medical Managed Care program.

The DHCS has reviewed the recommendations and is identifying those that it can implement with existing resources in the immediate future. Many of the recommendations will require additional work and consultation with stakeholders before the Department can proceed, and others will require similar effort and significant resources. For these reasons, DHCS implementation of supported recommendations would take place over an extended period of time, contingent upon receipt of necessary resources, including appropriate rate adjustments for the contracted health plans.

## **Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions**

The California HealthCare Foundation (CHCF), with several key partners, sponsored a project to develop recommendations to the Department of Health Care Services (DHCS) for Medi-Cal Managed Care performance standards specific to persons with disabilities and chronic conditions. The key partners, consisting of the Center for Disability Issues and the Health Professions at the Western University of the Health Sciences, the Center for Health Care Strategies, the Lewin Group, an Advisory Group and several work groups, developed the recommendations over a period of approximately nine months and delivered them to the DHCS on November 21, 2005. The recommendations are accompanied by a literature review, examination of applicable law at both the State and federal levels, and input from a series of workgroup meetings. The DHCS will support this process by providing information and responding to questions on current policies, procedures and practices in its administration of the Medi-Cal managed care program. This report provides the DHCS review and response to those recommendations.

The DHCS Medi-Cal Managed Care Division (MMCD) reviewed all fifty-three recommendations to determine how the recommendations would affect the delivery of care to Medi-Cal beneficiaries and existing policies and procedures and which recommendations it could adopt and implement as recommended or with modification. Attachment A provides a description of the public comment received.

The CHCF recommendations seek to create or enhance contract requirements and program policies and procedures specific to the needs of persons with disabilities and chronic conditions. The DHCS believes that many of the recommendations are also applicable to seniors (persons aged 65 and older) and will consider this when proceeding with planning and implementation.

The DHCS also considered two major factors in its analysis of the recommendations:

- Cost – implementation of many of the report recommendations will require additional State resources and funding to acquire expertise and deliverables to implement the changes.
- Rates – a number of report recommendations would impose additional contractual requirements on Managed Care Organizations<sup>1</sup> (MCO) that the DHCS does not currently require. Implementation may require the State to

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<sup>1</sup> The California HealthCare Foundation report uses the term “managed care organization (MCO)” to describe the Medi-Cal managed care health plans. For purposes of consistency, DHCS will use the same term throughout this document.

consider increasing capitation rates to provide adequate compensation to MCOs for the increase in scope of responsibility.

While agreeing with the principle behind most of the recommendations, the potential cost for increased capitation rates to plans, additional staff resources, MCO resources, and system development and enhancements are critical factors that the DHCS must consider before implementation of many of the CHCF recommendations can occur. The DHCS response to the recommendations should not be viewed as a commitment of state funds, and implementation of any recommendations in the CHCF report, or as modified by the DHCS, will be subject to funding availability. The DHCS has not developed funding estimates for the purpose of this response, and it would utilize the State's priority setting and budget process to pursue any resources necessary for implementation.

Performance standards related to Medi-Cal managed care beneficiaries with disabilities and chronic conditions should result in improved access, quality of care and improved health outcomes for this population. Such standards also could help the State realize cost containment in the Medi-Cal program to the extent that they facilitate enrollment of beneficiaries with disabilities and chronic health conditions.

The recommendations (with acronyms) in the CHCF report are grouped into eight major categories:

- **CC** Cross-Cutting Issues
- **ES** Enrollment and Member Services
- **NC** Network Capacity and Accessibility
- **BM** Benefit Management
- **CM** Care Management
- **QI** Quality Improvement
- **PM** Performance Measurement
- **CCO** Coordination of Carve-Out Services

### **Description of Recommendation Lettering and Numbering**

The CHCF recommendations suggest changes to either the MMCD Medi-Cal Managed Care contracts or other state agency functions and policies. Letters specifying the work group that developed it and to which the recommendation applies, i.e. the contract or the State, label each recommendation. For example, "CR" means contract recommendation and "SR" means State recommendation. Additional example: "ES-CR-1" means the Enrollment and Member Services workgroup developed the recommendation and it is a recommendation to change the contract.

This document lists the fifty-three recommendations in the CHCF report and the DHCS response to each recommendation.

## Recommendations and Responses

**CROSS CUTTING ISSUES:** This category includes standards that cut across several issue areas of the Medi-Cal Managed Care program.

**CHCF Recommendation 1:** CC-CR-1, Priority 2 - Important (contract change)

“The MCO shall conduct disability cultural competency and sensitivity training, including information about:

- Various types of chronic conditions and disabilities prevalent among Medi-Cal beneficiaries;
- Awareness of personal prejudices;
- Legal obligations to comply with the Americans with Disabilities Act (ADA);
- Scope of benefits, including range of carve-out services, how to refer people to services covered by other state agencies, and information on the availability of standing referrals for specialists and specialists as Primary Care Providers (PCPs);
- Definitions and concepts such as communication access, medical equipment access, physical access, and access to programs; and
- The types of barriers that adults with physical, sensory, communication disabilities, developmental or mental health needs face in the health care arena and the resulting access and accommodation needs.

Training shall be customized as appropriate for different audiences (e.g., MCO staff, network providers).”

**DHCS response:** The DHCS agrees with this recommendation.

Implementation of this recommendation should occur after completion of Recommendation 4, (CC-SR-1). Recommendation 4 calls for the state to develop a statewide education strategy for providers for use by all MCOs to provide an awareness of the disability culture and the competence and sensitivity required in serving individuals living with disabilities.

**CHCF Recommendation 2:** CC-CR-2, Priority 1 - Essential (contract change)

“The MCO shall attempt to contact all new members for whom an initial screen was not conducted by the enrollment broker, within 30 days of enrollment to administer the initial screen. The purpose of the initial screen is to identify: (1) members who have complex or serious medical conditions; (2) essential health care needs that may require an expedited appointment with an appropriate provider; (3) any access or accommodation needs, language barriers, or other factors that might indicate that the new member requires additional assistance from the health plan; and (4) any caregivers or other decision-makers involved in the member’s care. If the MCO is unable to complete the screen within three

attempts (either at different days/times or through different mechanisms such as mail, telephone, in person visit) within 90 days, or in the event that a member refuses to participate in a health screen, the MCO shall document that the screen was not completed and encourage the member to schedule an appointment with his or her PCP.”

**DHCS response:** The DHCS agrees with this recommendation.

Implementation of this recommendation should occur in coordination with Recommendation 5, (CC-SR-2) suggesting the State develop a standardized initial health screen to determine disabilities, chronic conditions, or transitional services needs including the need for care coordination and alternative forms of communication to ensure full access to the PCP, including preventive services and accessibility of informing material. Modifications to this recommendation may be necessary depending on implementation of CC-SR-2.

**CHCF Recommendation 3:** CC-CR-3, Priority 1 - Essential (contract change)

“The MCO shall have meaningful consumer participation in health plan decision-making and advisory processes.”

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS can amend current MCO contract provisions relating to consumer participation to specify inclusion of people with disabilities and chronic conditions and providers who serve them. The DHCS can develop guidance for MCOs on effective methods to include representation from these individuals and their providers in appropriate committees and in a meaningful way.

**CHCF Recommendation 4:** CC-SR-1, Priority 3 - Ideal (state agencies)

“The state should develop a statewide education strategy for providers, which could be used by all MCOs. The state should consider developing standardized training materials for use by health plans. “

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS would need to determine how to best approach this recommendation and Recommendation 1, (CC-CR-1). The current MCO contracts, with the exception of the COHS contract boilerplate, which is being amended, require provider training. The DHCS recognizes the need to provide and require disability cultural and sensitivity training, which is enduring and self paced (such as on-line training). Currently the DHCS has a Health Education Policy, which addresses these areas (PL-02-04). The DHCS could take a two-phase approach. First, the DHCS would identify gaps in existing policy to define what the training must achieve and include. The DHCS would then identify experts

and stakeholders to assist in developing the appropriate curriculum or identify an existing curriculum with the required components. The DHCS could then require MCOs to use the developed (or comparable) curriculum and or establish a central resource of recommended modules to use for training as recommended in Recommendation 1.

**CHCF Recommendation 5:** CC-SR-2, Priority 1 - Essential (state agencies)

“The state should develop a standardized initial health screen to determine any disabilities, chronic conditions, or transitional services needs. This initial health screen would be administered by the enrollment broker, who would transmit the findings from the screen to the selected (or assigned) health plan.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

The DHCS agrees with the importance of early identification of individuals with disabilities, chronic conditions, or needs for transitional services. The DHCS will explore how best to implement this recommendation including who would be the best administrator of an initial member health information screen. The DHCS could then implement Recommendation 2, (CC-CR-2) accordingly.

**CHCF Recommendation 6:** CC-SR-3, Priority 1 - Essential (state agencies)

“The state should provide health plans with member-specific, historical fee-for-service, claims information, and pharmacy data for members who are entering Medi-Cal managed care as well as for those currently in the program who are accessing carved-out services.”

**DHCS response:** The DHCS agrees with the intent of this recommendation to provide plans with data to assist with readiness in serving these individuals, however, it may need modification to implement. The DHCS would determine mechanisms to gather and provide this data to the MCOs in an appropriate manner, including aggregate data.

Implementation of Recommendations 34, 37, 38, 41 and 29 (QI-CR-1, QI-CR-4, QI-CR-5, QI-SR-1 and CM-CR-4 respectively) relies on this recommendation. If the DHCS is able to implement Recommendation 5, (CC-SR-2), MCOs will have early access to member health information.

The DHCS can provide aggregate data but systems issues and privacy law provisions may impair or delay its ability to provide member specific data. An associated concern with this recommendation is that in the absence of mandatory enrollment, this data could be used in an unscrupulous manner to encourage disenrollment of those individuals with poorest health.

**CHCF Recommendation 7:** CC-SR-4, Priority 3 - Ideal (state agencies)

“DHCS, Department of Managed Health Care (DMHC), and MCOs should continue to improve mechanisms for informing members and providers of appeal rights and the various mechanisms through which these can be done (e.g., filing appeals and limitations for each appeal mechanisms). People with disabilities and chronic conditions should be involved in the development of materials to ensure that members understand their rights and the procedures available to them.”

**DHCS response:** The DHCS agrees with the intent of this recommendation.

The DHCS and the DMHC currently, and will continue to provide various mechanisms for informing members and providers of their appeal rights. Examples include enrollment packet information, Notice of Action letters, quarterly DHCS notice on Fair Hearing Rights, and MCO member informing materials. In addition, the DHCS sends an annual letter of eligibility notification to all Medi-Cal beneficiaries, which contains information on the Member’s Rights and Responsibilities including Fair Hearing information. The DHCS will review the need to make this material available in alternative formats, such as larger print and audio as well as plain language to ensure all beneficiaries have access to this information.

DHCS and the California Department of Social Services work together on Fair Hearings and meet quarterly to discuss various Fair Hearing related issues including informing material, literacy and language or policy related issues. The DHCS collaborates with DMHC to ensure health plan compliance with Fair Hearing language and notification requirements. The DHCS will bring issues around alternative and plain language formats to these discussions.

**CHCF Recommendation 8:** CC-SR-5, Priority 2 - Important (state agencies)

“The state should have a process for engaging local representation to discuss issues related to any expansion of the Medi-Cal managed care program to enroll people with disabilities or chronic conditions.”

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS currently has a process for including advocates in discussions on managed care program expansions via the existing Medi-Cal Managed Care Advisory Group. The DHCS will present and discuss proposed new performance standards and development of education and outreach material targeting seniors and persons with disabilities. The DHCS will continue to ensure that people with disabilities and or chronic conditions or representatives of these individuals are engaged in discussions related to the expansion of the Medi-Cal Managed Care program at both the state and local levels.

**CHCF Recommendation 9:** CC-SR-6, Priority 2 - Important

“The state should develop and support an independent, community-based system designed to assist beneficiaries with system navigation and issue advocacy.”

**DHCS response:** The DHCS disagrees with this recommendation.

The DHCS currently has mechanisms in place to address system navigation (via the Health Care Options enrollment contract, Office of the Ombudsman and health plan member services departments) as does the Office of the Patient Advocate. The DHCS will bring this issue to these entities to determine respective roles, clarify how members receive such services, and determine any critical gaps for follow-up. Use of independent community based organizations for this function would require additional funding for contracts for functions that the State or health plans are already providing.

The DHCS has obtained funding for a contract with the University of California Berkeley, School of Public Health to develop education and outreach material targeting seniors and persons with disabilities. Additionally, it will work with community-based organizations to identify other strategies to help inform and increase voluntary enrollment of these Medi-Cal beneficiaries, including addressing the issues of system navigation. Implementation of Recommendation 12, (ES-CR-2), also addresses the proposed intent of this recommendation.

**CHCF Recommendation 10:** CC-SR-7, Priority 2 - Important (state agencies)

“Staff from the Medi-Cal Managed Care Division and from Audits and Investigations (A&I) should work together to develop auditing standards and tools to measure and monitor MCO compliance with the new performance standards and contract specifications implemented as part of the process of enrolling people with disabilities and chronic conditions. The DHCS also should develop additional mechanisms to monitor compliance with essential or priority contract specifications.”

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS coordinates with the DHCS Audits and Investigations and the DMHC on audits and would work with them on any audit issues arising from any new contract requirements. The DHCS will also ensure that appropriate monitoring mechanisms are in place consistent with any new contract requirements.

**ENROLLMENT AND MEMBER SERVICES:** These recommendations suggest changes to address member transition into managed care, improve Medi-Cal member advocacy, and provide written materials in alternative formats.

**CHCF Recommendation 11:** ES-CR-1, Priority 1 - Essential (contract change)

“The MCO shall work with FFS providers (for people newly enrolled in managed care) or other MCOs (for people switching between MCOs) to ensure that:

- An ongoing course of treatment is not interrupted or delayed due to the change to new providers; and
- Medical record information is transferred to new providers in a timely fashion.

To the extent possible, the transition from a non-network fee-for-service provider to an in-network provider shall be accomplished within 60 days. The MCO or in-network provider shall work with the non-network provider to facilitate the transfer of medical record information. If a member sees an out-of-network provider during the 60-day transition period for part of an ongoing course of treatment or services approved prior to enrollment in managed care, the MCO shall reimburse the provider at the prevailing Medi-Cal fee-for-service rate.

In addition, if a member transitions from the MCO to another MCO or back to the fee-for-service system, the MCO also shall provide assistance in coordinating referrals and transitioning medical records.”

**DHCS response:** The DHCS agrees with the intent of this recommendation; however, it would not implement all aspects. The DHCS currently requires MCOs to meet this requirement except for transferring medical records and the reimbursement of out-of-network providers.

MCO contracts currently include language to ensure members’ care is not interrupted and continuity of care is maintained when enrolling in a managed care plan. In addition, MCOs must provide new enrollees with membership material within 7 days and assign a primary care provider within 45 days if the beneficiary does not choose one. These requirements ensure that MCOs integrate beneficiaries moving from the fee-for-service program into the managed care system as soon as possible and in less than 60 days.

While the transfer of medical record information is important for ensuring continuity and coordination of care, this function remains a confidentiality issue and can occur only at the request of the member or by a representative with authority to act on the member’s behalf.

The DHCS cannot implement or enforce this part of the recommendation because it is patient-driven; however, the DHCS can work with plans on a process to facilitate the transfer in collaboration with beneficiaries. Mechanisms

based on existing statutes and professional protocols currently exist to allow beneficiaries to request the timely transfer of medical information. Patients must authorize the transfer of their medical information before providers can transfer their records, and transfer processes may vary by provider (physicians, hospitals, etc.).

The DHCS cannot require the MCOs to reimburse out-of-network providers the prevailing Medi-Cal fee-for-service rate because non-network providers, with the exception of emergency services, are not required to accept the rate offered by MCOs. To ensure continuity of care, MCOs are required to provide specialty care necessary to treat specific medical conditions that fall beyond the scope and expertise of the PCP. If specialty care is unavailable within the plan network, the plan must make arrangements to provide members with access to such care out of the network.

**CHCF Recommendation 12:** ES-CR-2, Priority 2 - Important (contract change)

“The MCO shall develop a policy for providing support to beneficiaries with chronic conditions and disabilities. This responsibility includes assisting members with complaint and grievance resolution, and investigating and resolving access and disability competency issues. In addition, the MCO shall designate a staff person with responsibility for overseeing disability-related issues, including monitoring compliance with the MCOs ADA compliance plan, functioning as a contact for beneficiary advocacy groups, and working with these groups to identify and correct the beneficiary’s access barriers.”

**DHCS response:** The DHCS agrees with the intent of this recommendation modified to allow MCO discretion in designating staff.

The DHCS agrees that MCOs should meet the needs of persons with disabilities and chronic conditions through policies and procedures, with oversight of related disability issues, and work with advocacy groups to improve access. The current contract requirements do not require that one specific staff person oversee issues specific to disability. However, the contract requires MCOs to designate a person responsible for all complaints and grievances for the entire MCO membership. The DHCS will provide the MCOs discretion to either designate specific staff that has the authority to resolve disability-related issues or assure that their current member services activities meet this need. The DHCS will also provide information on how some of the contracted MCOs have implemented different and effective methods of addressing this need.

**CHCF Recommendation 13:** ES-CR-3, Priority 1 - Essential (contract change)

“Written materials must be available upon request in alternative formats in a timely fashion. For the member services guide, the MCO will make such materials available within seven business days. For all materials, the MCO will have procedures in place for converting materials to alternative formats when requested by a member.

The MCO shall have a mechanism for a member to make a standing request for all materials to be provided in a specified alternative format.”

**DHCS response:** The DHCS agrees with this recommendation.

While current contracts require materials in alternative formats, timelines are not well defined. The DHCS agrees that it should coordinate with MCOs to establish appropriate timelines for responding to requests for materials in alternative formats. Contract language regarding written member information will be amended as appropriate. Additionally, the DHCS can review and develop contract language to require a mechanism for a member to make a standing request for all materials to be provided in a specified alternative format where determined appropriate.

**NETWORK CAPACITY AND ACCESSIBILITY:** These recommendations suggest modification to how MCOs assess and inform members about physical access to providers; enhancing accommodation policies; and how the State defines and evaluates “accessibility”.

**CHCF Recommendation 14:** NC-CR-1, Priority 1 - Essential (contract change)

“The MCO shall identify areas of provider accessibility for members with disabilities and chronic conditions. The MCO will use the DHCS-enhanced FSR (*facility site review*) tool, along with additional information related to physical and non-physical accommodations. At a minimum, the MCO shall make the following information related to access available to members through various communication mechanisms, such as the provider directory, website, and member services staff:

- Building walkway/access
- Parking
- Reception/waiting area
- Exam room
- Restrooms
- Accessible scales
- Exam table
- Auxiliary aides and services
- Public transportation access”

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS has not developed an enhanced FSR tool, but it is working to develop one. Some contracted MCOs are using their own plan developed tool to measure access. Several MCOs are currently piloting an enhanced FSR tool. The DHCS can determine the results of these pilots to determine feasibility of implementing a short-term solution using these enhanced tools and any associated training in their use, while working with MCOs and advocates on a longer term access tool. This recommendation will require consultation with the DHCS Office of Civil Rights and other appropriate entities to ensure it addresses applicable elements of the Americans with Disabilities Act (ADA). Recommendation 16, (NC-CR-3), which proposes MCOs develop an accessibility plan for members with disabilities, advises additional mechanisms to enhance this recommendation.

**CHCF Recommendation 15:** NC-CR-2, Priority 1 - Essential (contract change)

“The MCO shall submit policies and procedures on how it will enable members to access services. These policies shall address:

- Lifting policy and procedure;
- Flexible appointment time and length;
- Provision of service in alternative locations; and
- Use of identified facilitators - for people unable to express their own unique needs, the MCO shall identify and utilize one-on-one facilitators capable of representing the person with a disability or chronic condition.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to the requirement of MCOs having one-on-one facilitators.

MCO contracts do not currently include a lifting policy and procedure, or flexible appointment length provision; however, there is a contract provision to allow for services at alternative locations through compliance with Title III of the Americans with Disabilities Act of 1990. The DHCS contracts also require plan facilities to comply with requirements of Title III of the American Disabilities Act of 1990 and ensure access for the disabled. The DHCS will work with MCOs and advocates to identify and share model policies and training that successfully address how plans enable members with special needs to access services. The DHCS will work with MCOs to facilitate the identification of providers within the plan network that have medical practices that allow access for persons with specific disabilities. These providers can serve as a referral base for members with disabilities and can share their accomplishments with other practices.

The MCOs should have discretion in addressing requests or need for one-on-one facilitators capable of assisting the person with a disability or chronic conditions.

**CHCF Recommendation 16:** NC-CR-3, Priority 2 - Important (contract change). This recommendation is associated with Recommendations 14 and 15 (NC-CR-1 and NC-CR-2).

“The MCO shall file an annual ADA Accessibility Plan with DHCS.

*Standard for Accessibility Plan:* Member services sites and functions will be made accessible to and usable by people with disabilities and chronic conditions by way of physical, communication, program, and equipment access.

The ADA Accessibility Plan must:

- Set goals, list priority activities, and commit resources for increasing accessibility to the services and activities of all MCO providers for members with disabilities and chronic conditions;
- Include goals related to aspects of accessible health care such as (i) disability literacy and competency training for MCO member services staff and health care providers; (ii) ongoing identification of existing physical, equipment, communication, transportation and policies and procedures barriers encountered by MCO members with disabilities and chronic conditions; (iii) strategies for removing the identified barriers; and (iv) gathering and incorporating feedback from consumers with disabilities and chronic conditions;
- Develop, track, and report on a list of key indicators used by the plan to track progress toward plan goals;
- Identify staff responsible for coordinating the implementation of the accessibility and accommodation goals set out in the plan;
- Provide information on the disability literacy and competency training provided to member services staff (e.g., training schedule, content);
- Contain an organizational chart showing the key staff people/positions who have overall responsibility and/or practical responsibility for implementing the accessibility and accommodation goals set out in the plan;
- Include a narrative explaining the organizational chart and describe the oversight and direction;
- Provide a summary report of data regarding complaints and grievances related to people with disabilities and chronic conditions;
- Be updated annually;
- Be made public and posted on the MCOs web site.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to the title of “ADA Accessibility Plan” and the method by which to fulfill the intent.

Recommendations 14 and 15 (NC-CR-1 and NC-CR-2) should be implemented simultaneously with this recommendation.

The title of “ADA Accessibility Plan” could be interpreted by some to mean that the DHCS would be certifying MCOs and providers as ADA compliant. Federal guidelines already exist for all MCOs and the responsibility for state enforcement of ADA compliance lies with the California Department of Justice. To avoid any confusion or misinterpretation of responsible party for ADA compliance, the DHCS recommends changing the title of this plan.

The numerous elements of the plan are too prescriptive and do not allow for flexibility. The first two bullets are sufficient and encompass the essence of the recommendation.

The DHCS recommends requiring MCOs use a survey tool to identify accessible providers. MCOs can identify providers that they determine comply with the MCO’s “access” tool would be identified in their provider directories (See Recommendation 14, (NC-CR-1). The survey tool should also include elements of the pilots that used the enhanced FSR tool suggested in Recommendation 14. The MCOs would assume responsibility to monitor provider compliance and provide flexible policies to ensure access. The DHCS site visits can confirm that the MCOs completed the site surveys.

**CHCF Recommendation 17:** NC-CR-4, Priority 2 - Important (contract change)

“The MCO provider directory shall include information on accessibility, determined through the FSR process. Information on accessibility also shall be included for specialty/ancillary providers and services when available through sources other than the FSR and be provided to members upon request.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to how the information on “accessibility” is collected or determined.

This is related to Recommendation 14, (NC-CR-1); that is, the MCO must first use an effective tool (as proposed in NC-CR-1) to identify and include the information advised in this recommendation.

The intent of this recommendation is to make members aware of the services available to them for their particular needs and assist them in selecting an appropriate provider. While there is agreement with this intent, the DHCS is not authorized to certify a provider as “ADA” compliant. (See proposed revisions to Recommendation 16, NC-CR-3).

The DHCS can evaluate the result of the enhanced FSR tool pilot project currently underway (discussed in Recommendation 15, (NC-CR-2) and develop criteria based upon the findings. In addition, MCOs and advocacy groups have convened workgroups (prior to these recommendations) to come up with

symbols and appropriate definitions that could be used in provider directories. The DHCS could build upon existing work in this area.

The DHCS supports accessibility information but it should not be a requirement until the DHCS has been able to analyze fully results of ongoing MCO efforts.

**CHCF Recommendation 18:** NC-CR-5, Priority 1 - Essential (contract change)

“The MCO shall use the relay service (711 or TTY) for people with speech disabilities and for the deaf and have mechanisms to ensure that members can be responded to within required telephone and after-hour calls standards.”

**DHCS response:** The DHCS agrees with this recommendation.

The DHCS can amend current contract language to specifically require MCOs to utilize the 711/TTY relay service. Most MCOs currently utilize this service even though the contract does not require it. Current MCO contracts specify the use of Telecommunications Device for the Deaf (TDD), and the DHCS would need to include specific contract language to include “hearing” and “speech” as they address different needs. In addition, the DHCS can amend the contract to add definitions of TDD and 711/TTY.

There is no cost associated for the use of the speech-to-speech relay service to the MCO or the caller except there may be normal long distance toll charges to the caller (depending where they are calling from.).

**CHCF Recommendation 19:** NC-CR 6, Priority 2 - Important (contract change)

“The MCO shall submit policies and procedures for providing a “medical home” if the member has a disability or chronic condition. These policies shall require the primary care provider (PCP) to assess a patient’s needs for specialty referrals and coordinate with specialists after referrals are made.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification and could implement it through the care management Recommendations 26 through 32 (CM-CR-1 through CM-CR-7).

This standard already exists for MCOs. Current contract language defines a “medical home” within the definition of a primary care provider. The California Welfare and Institutions Code (W&I) § 14088-14088.25 defines (1) “Primary care provider” means the following:

- (A) Any internist, general practitioner, obstetrician/gynecologist, pediatrician or family practice physician or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic holding a valid Medi-Cal

provider number which agrees to provide case management to Medi-Cal beneficiaries.

The contract also requires MCOs to provide case management but does not list specific required training or functions for this service. The DHCS recognizes the need for better coordination of care and supports the care management recommendations presented further in this report. Contract language can be strengthened to address the intent of this recommendation.

This recommendation appears to expand the role of a specialist to function as a primary care provider. The DHCS acknowledges the need for members with disabilities and or chronic conditions to have ready access to specialists and current contract requirements allow standing specialist referrals to ensure this access.

**CHCF Recommendation 20:** NC-SR-1, Priority 3 (state agencies). This recommendation is associated with Recommendation 10, (CC-SR-7).

“The MCOs Accessibility Plan should be incorporated into the DHCS Audit and Investigation review.”

**DHCS response:** The DHCS agrees with this recommendation. The DHCS can consider this recommendation for implementation after the determination of adopting Recommendation 16, (NC-CR-3).

The MMCD informs DHCS Audits and Investigations of contract changes. Audits and Investigations then incorporate new requirements into their audit review process as directed by the MMCD. The DHCS could allow a phase-in period for MCOs newly proposed accessibility plans over a period of two to three years. The DHCS could then determine if Audits and Investigations should evaluate MCOs’ accessibility plans through an audit.

**CHCF Recommendation 21:** NC-SR-2, Priority 2 - Important (state agencies)

“The state should use the following definitions regarding accessibility:

- Access to programs and services: Accommodations are made to enable services, programs, network providers, or activities to be accessible and usable by people with disabilities and chronic conditions;
- Accessible website: Accessible websites are constructed in accordance with the guidelines provided by the World Wide Web Consortium ([www.w3.org/WAI/](http://www.w3.org/WAI/)) in its Web Accessibility Initiative. An accessible website should meet the requirements of Section 508 of the 1973 Rehabilitation Act; and

- Accommodations: Modifications of MCO and/or providers' policies and practices that respond to the individual needs and characteristics of people with disabilities and chronic conditions necessary to access health services. Examples include:
  - Physical access and access to medical equipment such as (accessible: paths from public transportation drop off points, parking (curb cuts, ramps), examination, treatment, dressing, rest rooms, etc;
  - Appointment flexibility;
  - Environmental modifications (sensory overload, auditory, visual, tactile); and
  - Use of auxiliary aides and services, such as 1:1 facilitators able to identify and express a person's methods and unique communications necessary to respond to a person's needs.
- Alternative formats: Acceptable alternative formats for member materials include Braille, large print, disks, audio formats, and electronic formats;
- Auxiliary aides and services: Qualified interpreters, qualified readers, note takers, computer-aided transcription, 1:1 facilitators (for people with learning and understanding disabilities), telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, open and closed captioning, e-mail or other electronic communications. Use of telecommunications devices [TTY's] for enrollees who are deaf, hard-of-hearing or have speech disabilities; video text displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments; and/or qualified readers, taped texts, audio recordings, Braille materials, and large print materials for individuals with visual disabilities;
- Communication access: Providing content through methods that are understandable and usable by people with reduced or no ability to speak, see, and/or hear, and limitations in learning and understanding;
- Medical equipment access: Equipment that is usable by people with disabilities and chronic conditions including scales, height-adjustable exam tables, exam chairs and other diagnostic/radiological equipment facilitating access to routine care, preventive care, diagnostic tests, and necessary treatments; and
- Physical access: Ability to get to, enter, and use examination rooms, treatment areas, dressing rooms, rest rooms, and other provider sites/services."

**DHCS response:** The DHCS does not agree with this recommendation as it extends beyond DHCS authority.

The DHCS must comply with current federal and State law definitions relating to accessibility. The DHCS does not have the authority to redefine these terms and believes that these terms should not be redefined. To the extent new contract requirements introduce new terms specific to persons with disabilities and chronic conditions, the DHCS will add terms and definitions as appropriate.

**CHCF Recommendation 22:** NC-SR-3, Priority 2 - Important (state agencies)

“When considering a MCOs request for exceptions, the DHCS should consider current community standards of care and/or the California Rural Health Policy standards defining “urban”, “rural”, and “frontier”. In addition, the DHCS’ assessment should include a review of the distribution of disabled enrollees within the service area.”

**DHCS response:** The DHCS’ understanding of this recommendation focused on access standards, not community standards of care as written in the recommendation; therefore, the DHCS’ response is directed to the accessibility standard.

1. “The DHCS should consider a) current community standards of care and/or b) the California Rural Health Policy standards defining “urban”, “rural”, and “frontier”.
  - a) The DHCS agrees with this part of the recommendation as the DHCS currently uses community standards of practice when assessing time and distance for accessibility.
  - b) The DHCS does not agree with this part of the recommendation.

It would be extremely difficult and possibly detrimental to the Medi-Cal population to impose a uniform standard for exceptions to the 10 mile and 30-minute access standard given the geographic and demographic variances in the state. However, existing policies allow members to choose voluntarily to access a provider beyond time and distance standards in order to access a preferred provider.

2. “The DHCS’ assessment should include a review of the distribution of enrollees with a disability in the service area.”

The DHCS agrees with this part of the recommendation.

The DHCS applies Title 28 accessibility standards to all MCOs when assessing network adequacy including exceptions to time distance standards. The DHCS

requires MCOs to comply with Title 28 regarding exceptions to accessibility standards. The DHCS recognizes the challenges of specialist availability in less populated areas but follows Title 28 standards of practice rules that allow exceptions to accessibility standards when certain specialists are not available in less populated areas.

The second part of this recommendation is achievable as long as data on beneficiaries with disabilities in fee-for-service are available. (As these individuals move into managed care, fee-for-service data would no longer be available.) The DHCS currently considers the distribution of the eligible Medi-Cal beneficiary population when evaluating provider networks. The DHCS can revise its current assessment of MCOs provider networks to include a review of the distribution of Medi-Cal beneficiaries with disabilities.

**BENEFIT MANAGEMENT:** These recommendations relate to the criteria used to determine medically necessary services.

**CHCF Recommendation 23:** BM-CR-1, Priority 2 - Important (contract change)

“The MCO shall consider the following when reviewing coverage policies or requests for new technology and investigational treatments:

Effectiveness should be determined based on scientific evidence. If insufficient scientific evidence for people with disabilities or chronic conditions is available, professional standards must be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions must be made based on consensus expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive evidence.”

**DHCS response:** The DHCS agrees with the recommendation.

Current State law provides the DHCS policy on covered benefits. The current Medi-Cal managed care standards address "coverage policies or requests", but do not mention "new technologies and investigational treatment", "scientific evidence," "professional standards", or "consensus expert opinion". Medical policies and procedures are created by researching the scientific evidence. The medical needs of the individual are reviewed and investigational treatment is considered and may be approved if medically indicated. Title 22 provides Medi-Cal fee-for-service standards that give criteria for authorization of investigational services, and these same standards govern MCOs. The DHCS will review and amend current MCO contract language to provide for or refer to the appropriate sections of Title 22 to address the conditions under which investigational treatments are covered.

**CHCF Recommendation 24:** BM-CR-2, Priority 2 - Important (contract change)

“The MCO shall use a qualified physician with appropriate clinical expertise with the members’ condition(s), disability (ies), or disease(s) to review all denials”.

**DHCS response:** The DHCS agrees with the intent of this recommendation. However, current contract language covers the core elements of this standard.

Current contract language requires that a qualified physician or qualified health care professional review all denials of care. In addition, Health and Safety Code 1367.01 requires any denial be made by a health care professional that has expertise in treating the enrollee. Medi-Cal Managed Care plans seek outside consultation for assistance in authorizing newly available, unusual, or rarely requested services. The DHCS will raise this issue with contracted MCOs and determine whether they need additional guidance.

**CHCF Recommendation 25:** BM-CR-3, Priority 1 - Essential (contract change)

“The MCO shall arrange for the provision of specialty services from specialists outside the network if unavailable within the MCO’s network, when determined medically necessary.”

**DHCS response:** The DHCS agrees with the recommendation. Current contract language addresses the intent of this recommendation.

Contract language supports the use of specialty services from specialists outside the network if unavailable within the MCO’s network. In addition, the current contract allows for standing referrals to out of network specialists. The DHCS will raise this issue with contracted MCOs and discuss how they are meeting the prevention and maintenance needs of persons with disabilities and chronic health conditions.

This recommendation also proposes that the DHCS remove the terms “seldom used” and “unusual” when referring to specialty services. Revision of that particular area of the contract would not enhance access to specialist care and is not necessary.

**CARE MANAGEMENT:** These recommendations present the vision for care management and distinguish it from case management.

**CHCF Recommendation 26:** CM-CR-1, Priority 1 - Essential (contract change)

“The MCO shall use the following definition for care management: “Care management includes identification and assessment of member needs, advocacy, facilitation and coordination of plan, carved-out and “linked” services (not covered under the Medi-Cal program but described in the contract as related

social, educational, and other services needed by the member). The process should integrate the member's strengths and needs, resulting in mutually agreed upon appropriate services that meet the medical, functional, and medically-related social needs of the member."

**DHCS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management recommendations would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program.

The current MCO contracts include provisions that require MCOs to provide care management and coordination of care, including carved out services (Seventeen areas of the contract present provisions for coordination of care.). These recommendations can provide guidance and improve upon the DHCS' efforts to ensure better-managed health care for Medi-Cal beneficiaries.

The DHCS may consider piloting these recommendations in a COHS; however, it would require additional resources. A pilot to incorporate this recommendation could include MCO coverage of carve-out services if DHCS could secure all appropriate approvals.

**CHCF Recommendation 27:** CM-CR-2, Priority 1 – Essential (contract change)

"The MCO shall provide care management for members who are identified through the care management assessment mechanisms as having the need for greater care management than can be provided by the PCP. The MCO shall maintain procedures for providing care management, with the following elements included:

- Written description of the activities and responsibilities that are part of the care management process, including procedures for monitoring the coordination of care provided, including but not limited to medically necessary services delivered in and out of the MCO's provider network;
- Annual review and evaluation of the program description with approval by the MCO's governing body;
- Process for obtaining input into the development of the MCO's care management program and annual evaluation, including input from members (families/caregivers, as appropriate) and providers;
- Standardized procedures/description/methodology for identifying members for care management, including a process for self-referral;
- Description of the qualifications of people who will act as care managers, the approach for having sufficient staff available/monitoring case loads, and the appropriate methods for using a multi-disciplinary team;
- Description of the components of a care plan, including how it is developed and reviewed;

- Process for collaborating with carve-out programs to develop and distribute a quarterly contact list;
- Process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group;
- Process for obtaining member input on satisfaction with individual care manager services;
- Information systems to support monitoring/management of care plans, the care management program, communication and information sharing among care managers and providers;
- Process to regularly update care plans based on changes in the members' medical or social status; and
- Process to obtain information on recommendations made by nurses staffing after-hours advice lines.”

**CHDS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management recommendations would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program.

**CHCF Recommendation 28:** CM-CR-3, Priority 2 - Important (contract change)

“The MCO shall use qualified care managers, including licensed (or certified) registered nurses, social workers, rehabilitation counselors/therapists, physician’s assistants, physicians, or other appropriate qualified individuals. Care managers preferably have practice and experience meeting the needs of people with disabilities and chronic conditions and receive appropriate training (see Section II-1, Cross-Cutting Issues, for more information on training recommendations).”

**DHCS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management recommendations would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program.

**CHCF Recommendation 29:** CM-CR 4, Priority 1 - Essential (contract change)

“The MCO shall maintain procedures for identifying members for care management, which should include the following mechanisms:

- Member, family member, caregiver/guardian’s request;
- Referral from a specialist or PCP, or other provider (e.g., regional center, CCS provider);

- Referral from internal MCO staff (e.g., member services, complaints and grievances);
- Presence of an external care manager;
- Regular reviews of utilization and claims/encounter data, ER visits, lab, pharmacy scripts, DME, transplant request, and hospitalizations;
- Routine mining of claims/encounter data with algorithms established by the MCO;
- Triggers identified as being risk factors during initial screening of new members or during a later assessment (e.g., chronic homelessness/living arrangements, receipt of in-home supportive services, safety concerns, presence of a caregiver, enrollment in a county behavioral health program, enrollment in a community-based long-term care or contact with that system, regular visits to multiple specialists, presence of a cognitive impairment/certain conditions, missed appointment or referrals);
- Participation in multiple disease management programs (or identification or multiple conditions that could qualify for disease management); and
- Auto-assignment (of people in certain aid codes) to a PCP, which may indicate a concern with continuity of care.
- The MCO shall provide a written explanation of the reason the member was not placed in care management when the request was made by a member or his/her representative, or provider, and provide those reasons to the family/provider.

The MCO shall provide a written explanation of the reason the member was not placed in care management when the request as made by a member or his/her representative, or provider, and provide those reasons to the family/provider.

The MCO shall maintain a process of communicating the initiation and closure of the care management process to the member and PCP.”

**DHCS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management recommendations would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program. Additionally, implementation of Recommendation 34 (QI-CR-1 MCO using member data to develop and target QI activities and interventions) must occur to allow MCOs to meet the intent of this recommendation.

**CHCF Recommendation 30:** CM-CR-5, Priority 1 - Essential (contract change)

“The MCO shall maintain procedures for developing care plans for members who are identified through the care management assessment mechanisms as having the need for greater care management than can be provided by the PCP. The

care plan shall be developed by the care manager in collaboration with the PCP, treating specialists, interdisciplinary team (if indicated), and member (and his/her representative, if desired) that takes into account the following elements, as appropriate for each member:

- Health status and risk for secondary disabilities or complications;
- Clinical history;
- Age;
- Diagnosis/diagnoses;
- Functional and/or cognitive status;
- Mental health;
- Language/comprehension barriers;
- Cultural/linguistic needs, preference or limitations;
- Level of intensity of care management;
- Immediate service needs;
- Use of non-covered services;
- Barriers to care;
- Follow-up schedule;
- In or out-of-network care;
- Family members/caregiver/facilitator resources and contact information (if appropriate);
- Local community resources;
- Psychosocial support resources;
- Access/availability of needed medical equipment/accessible medical equipment;
- Assessment of progress, including input from family if appropriate; and
- Accommodation needs (e.g., appointment time), alternative formats (e.g., Braille, large print, disks, audio, electronic) and auxiliary aids and services.

The care plan shall be implemented and routinely monitored to ensure continuity of care. Information in the care plan should be made available to the member and PCP upon request. Additionally, the care plan shall be periodically evaluated to ensure that it continues to meet the member's needs. The MCO should have established criteria for discharge and transitioning members from care management.”

**DHCS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management recommendations would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program.

**CHCF Recommendation 31:** CM-CR-6, Priority 3 - Ideal (contract change)

“The MCO shall have policies and procedures that address the following aspects of the disease management program:

- Identification of diseases and conditions to be addressed by the MCO’s disease management program through several methods, e.g., claims analysis;
- Identification and stratification of members who may be appropriate for enrollment in disease/multiple chronic conditions management;
- Coordination with the PCP/medical home;
- Coordination/linkage with care management;
- Communication with the member; and
- Strategies for providing disease management for members with multiple chronic illnesses or conditions.”

**DHCS response:** The DHCS agrees with this recommendation with modifications.

This recommendation can improve and expand the current MCO contract for disease management and provides specific strategies to address specific conditions. However, considerable resources will be required from the MCOs. Some MCOs currently perform some level of these functions but not to the degree called for in the recommendation. The MCOs would need to be able to manage carved out services. The DHCS is conducting work in this area and implementation of this recommendation would be delayed until completion of certain special projects (Medi-Cal Policy procurement, and the Health Maintenance Support Program for chronic conditions, which is being tested over the next 12-18 months). The DHCS may also consider this recommendation in the implementation of the care management Recommendations 26 through 30 and 32 through a pilot project.

**CHCF Recommendation 32:** CM-CR-7, Priority 1 - Essential (contract change)

“The MCO shall submit policies and procedures describing how it will assist members in coordinating out-of-plan services, particularly for people who receive services from programs carved out of the capitated managed care program.

Cross Reference to Coordination of Carve-Out Services Section II-8 p72.”

**DHCS response:** The DHCS agrees with Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-CR-7) with modifications. The care management would enhance the DHCS Medi-Cal Managed Care program and should be considered under a pilot program.

**CHCF Recommendation 33:** CM-SR-1, Priority 3 - Ideal (state agencies)

“DHCS and the health plans should develop an ongoing working group that evaluates emerging best practices in care management, such as use of interdisciplinary teams, health information technology, and consumer directed models.”

**DHCS response:** The DHCS disagrees with the recommendation.

The DHCS acknowledges the desire to develop a mechanism for sharing information among MCOs. The DHCS may consider bringing MCOs together periodically to discuss what is working (e.g. the MMCD QI conference) and can facilitate the exchange of information about plan innovations. However, the State is not the appropriate entity for attempting to develop and evaluate best practices for care management. This would be a resource intensive role that the Department cannot sustain. The MCOs need to adopt models of care management that best serve the needs of their population. The DHCS is willing to facilitate a work group to discuss models of care management in conjunction with the implementation of recommendations CM-CR-1 through CM-CR-5 and CM-CR-7.

**QUALITY IMPROVEMENT:** These recommendations include using member data to drive and conduct quality improvement projects specific to people with disabilities and chronic conditions. There are significant personal health information and system issues in sharing data suggested in these recommendations.

**CHCF Recommendation 34:** QI-CR-1, Priority: 1 - Essential (contract change)

“The MCO shall use member data to identify and stratify disabilities and multiple chronic conditions to develop and implement targeted quality improvement activities and interventions.”

**DHCS response:** The DHCS agrees with this recommendation with modification including the implementation of a pilot.

The DHCS can identify mechanisms to facilitate MCOs’ receipt and use of member data. However, implementation of this recommendation is contingent upon the successful implementation of Recommendation 41 (QI-SR-1 the DHCS

providing MCOs with this data) and recommendation 6, (CC-SR-3 the DHCS providing member specific fee-for-service data).

To implement this recommendation, the DHCS must assess and evaluate carved-out services and access to data systems. Sharing of the data with other State departments or any other entity must be in a manner to avoid violating requirements for use of Personal Health Information (PHI). This is a significant challenge and will require collaboration between the DHCS and other State departments. Implementation of the data exchange required by MCOs must ensure that PHI requirements are maintained.

A potential option for the DHCS is piloting this recommendation in a COHS model health plan. The DHCS must consult with the DHCS Privacy Officer to ensure the use of PHI under this recommendation complies with all Health Insurance Portability and Accountability Act (HIPAA) requirements.

**CHCF Recommendation 35:** QI-CR-2, Priority 1 - Essential (contract change)

“The MCO shall stratify utilization data to capture statistically significant results for subcategories of its Medi-Cal enrollees. Sample size, sample selection,\* and implementation methodology shall be determined by DHCS, with MCO input, to assure comparability of results across MCOs.

\*The MCO may have to over sample its data to yield a statistically significant result.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

Establishing workgroups and other informal collaborative relationships with MCOs to capture, evaluate and develop uniform statistical methods applied to utilization data on beneficiaries who are disabled and or have chronic conditions would be of greater benefit as opposed to incorporating this recommendation into MCO contracts (see Recommendation 42, QI-SR-2 recommending the DHCS stratify risk adjusted utilization data and provide results in aggregate form). MCOs cannot conduct this activity unless the DHCS provides the data in Recommendation 42.

The DHCS may consult its External Quality Review Organization (EQRO) contractor to evaluate this recommendation’s feasibility.

**CHCF Recommendation 36:** QI-CR-3, Priority 2 - Important (contract change)

“The MCO shall collect utilization data in the following areas:

- Durable medical equipment; and
- Preventable hospitalizations.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

Satisfaction with durable medical equipment (DME) is not in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey administered by the DHCS' External Quality Review Organization (EQRO). This would place a significant financial burden on both the DHCS and the MCOs to implement.

The MCOs do not have access to out of plan utilization of DME and preventable hospitalizations (see recommendation 42, QI-SR-2 recommending the DHCS stratify risk adjusted utilization data and provide results in aggregate form and recommendation 34, QI-CR-1, which requires MCOs to use data to develop and implement targeted quality improvement activities and interventions). The DHCS can pursue this issue in a work group setting, rather than a contract change.

**CHCF Recommendation 37:** QI-CR-4, Priority 2 - Important (contract change)

“The MCOs shall conduct a QIP on an issue related to people with disabilities and chronic conditions. This project will be counted as the next statewide QIP and will require MCOs to collaborate and share data. For year one, MCOs should focus on issues such as access and consumer satisfaction. In years two and three, as MCOs begin to learn more about their new members, the quality improvement projects shall focus on improving clinical outcomes.”

**DHCS response:** The DHCS agrees with the intent of this recommendation if modified to have a later implementation date. Implementation of Recommendation 34, (QI-CR-1 MCO using member data to develop and target QI activities and interventions) must occur to allow MCOs to meet the intent of this recommendation.

The DHCS regularly reviews its Quality Improvement Projects (QIPs) to determine their continuing relevance and effectiveness. The DHCS agrees that at some point QIPs targeting people with disabilities and chronic conditions should be required and can require them at the appropriate time; however, the Department cannot bring new QIPs into the current cycle at the expense of existing QIP project work. QIPs require significant investment of MCO and DHCS resources and are monitored by the federal Centers for Medicare and Medicaid Services.

**CHCF Recommendation 38:** QI-CR-5, Priority 3 - Ideal (contract change)

“The MCO shall develop and implement a process for disseminating information to its providers through multiple strategies, both passive and active (e.g., passive: posting information on websites, or active: academic detailing), regarding best practices, evidenced-based standards, and guidelines (for those

that exist) for serving people with disabilities and chronic conditions. The information should be disseminated on an ongoing basis. The MCO shall outline a plan to train and educate providers on ways to implement the guidelines and standards of care.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

DHCS currently requires MCOs to develop and disseminate clinical practice guidelines or standards of care. However, contract language may be refined to better define or direct MCOs to disseminate evidence based standards and guidelines for those that already exist. In addition, the DHCS can consider requiring the MCOs QI Committees to review regularly which evidence-based standards they should disseminate, “including evidence-based clinical standards or guidelines for conditions affecting the SPD”.

**CHCF Recommendation 39:** QI-CR-6, Priority 2 - Important (contract change)

“The MCO shall include, on its Quality Improvement Committee or its subcommittees, physicians and psychologists who represent a range of health care services used by members with disabilities and chronic conditions.”

**DHCS response:** The DHCS agrees with this recommendation.

To accommodate this recommendation, the DHCS will consider changing existing contract language to read, “physicians and providers representing a range of health care services” rather than specifying “psychologist”.

A more comprehensive approach would be to amend contract language to read, “used by members including but not limited to seniors and persons with disabilities and or chronic conditions”, as opposed to using language that reads “used by member with disabilities and chronic conditions”.

**CHCF Recommendation 40:** QI-CR-7, Priority 2 - Important (contract language)

“As part of its written quality improvement system description, the MCO shall outline the components of its quality improvement activities addressing services (e.g., access/availability) and clinical (e.g., care management) improvements relevant for people with disabilities and chronic conditions.”

**DHCS response:** The DHCS agrees with this recommendation.

Most MCOs are already providing services that specifically address this population; this recommendation would not have significant impact.

**CHCF Recommendation 41:** QI-SR-1, Priority 2 - Important (state agencies)

“For year one of enrollment, DHCS should provide each MCO with stratified member data based on the most prevalent chronic conditions and disabilities.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to the type of data provided.

While this recommendation is achievable using the current data system, the DHCS must confirm that providing this would not violate privacy laws. This recommendation must be implemented in order to implement Recommendation 34, (QI-CR-1) which requires MCOs to use this data to develop and implement targeted quality improvement and interventions.

The DHCS recognizes the intent of providing data is to coordinate services more efficiently but Medi-Cal eligibles must be given the right to object to the release of personal information. One annual release of information may be possible contingent upon clarification from the privacy officer.

DHCS also recognizes the original intent of this recommendation was related to the Administration’s proposal to convert all managed care counties to mandatory enrollment of SPDs, which did not take place. However, as the Department brings up new counties for geographic expansion of managed care, it works with health plans to provide historical FFS data as they acquire membership to assist with their planning efforts.

**CHCF Recommendation 42:** QI-SR-2, Priority 1 - Essential (state agencies)

“DHCS should stratify risk-adjusted utilization data to capture statistically significant\* results for all categories of Medi-Cal enrollees and provide the results to MCOs in the aggregate form.

*\*The state may have to over sample its data to yield a statistically significant result.”*

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

The DHCS currently monitors the impact of enrollment of Medi-Cal eligibles in managed care plans. Development of measurements to evaluate utilization/access to care by eligibility category can be achieved through use of existing mechanisms. The intent of the recommendation is to “help MCOs assess reductions or increases in utilization during the first year following a member’s transition into managed care”. Although trending an individual plan’s data over a period may be of some use, comparison to other plans or statewide benchmarks would not necessarily help the plans to assess their future needs. The DHCS cannot provide MCOs with stratified risk adjusted utilization data because of the potential of identifying Medi-Cal beneficiaries even in aggregate

form. The DHCS can work directly with the MCOs to meet the intent of the recommendation.

**CHCF Recommendation 43:** QI-SR-3, Priority 2 - Important (state agencies)

“DHCS should select, as its next statewide collaborative quality improvement project (QIP), an issue related to people with disabilities and chronic conditions. For the first year, the MCOs should focus on issues such as access and consumer satisfaction. In years two and three, as the MCOs begin to learn more about their new members, their quality improvement projects should focus on improving clinical outcomes.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to the timing of its implementation.

This recommendation can be implemented later. As stated relative to recommendation 37, (QI-CR-4) that would require MCOs to conduct a QIP related to people with disabilities and chronic conditions, DHCS cannot bring new QIPs into the current QIP process and interrupt current project work. The DHCS agrees that it should further focus QIPs on people with disabilities and chronic conditions at the appropriate time.

**CHCF Recommendation 44:** QI-SR-4, Priority 2 - Important (state agencies)

“DHCS should facilitate one QIP designed to improve the quality of care across the MCOs and carve-out entities. The QIP must involve all the appropriate partners in the carve-out system (e.g., MCOs, Medi-Cal, and sister state agencies) and focus on one issue common to all parties (e.g., care coordination).”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to delay implementation until Recommendation 51 CCO-SR-1, CO-SR-1 is implemented.

A QIP specific to carved-out services, as proposed, would be difficult to conduct because of the different entities involved county by county and the lack of formal coordination between such entities at this time. Necessary measurable data is not always available from carved out services. Implementation of Recommendation 51 (CCO-SR-1, development of reciprocal, state-level, interagency MOUs among carve-out service departments) would need to occur so that desirable outcomes may be obtained through the implementation of this QIP.

In addition, the DHCS believes implementation of the care management Recommendations 26 through 30 and 32 (CM-CR-1 through CM-CR-5 and CM-

CR-7) could resolve perceived issues relating to the coordination of carved-out services.

**CHCF Recommendation 45:** QI-SR-5, Priority 3 - Ideal (state agencies)

“DHCS should charge its Quality Improvement Committee to work toward identifying gaps in clinical guidelines as they relate to people with complex needs and conditions. In areas where the Committee identifies gaps, it shall review related literature and use quality improvement projects to develop and test clinical guidelines that can then be applied to people with disabilities and chronic conditions. When making decisions, the Committee should take into consideration cost and appropriateness of the guidelines. In areas where guidelines already exist, the Committee shall work to reduce duplication of guidelines and tools by selecting a set of standardized guidelines for MCOs to implement.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modifications.

The DHCS can develop aspects of this recommendation that support the intent by conducting the following:

- evaluate and approve the guidelines that the MCOs choose to use; however, the DHCS does not prescribe how MCOs should operate;
- examine the extent to which contracts could be amended to include in their current QI policy and procedures, the needs of people with disabilities and chronic conditions, and or;
- work with the CHCF to identify gaps in guidelines and assist MCOs in accessing clearinghouse information sites.

**PERFORMANCE MEASUREMENT:** These recommendations relate to the collection of data to identify and address clinical and consumer satisfaction issues using Health Employer Data and Information Set (HEDIS) measures. It also includes the use of satisfaction surveys and provider incentives.

**CHCF Recommendation 46:** PM-CR-1, Priority 1 - Essential (contract change)

“The MCO shall stratify the following measures to capture statistically significant results for its SSI-eligible members:

- Appropriate use of medication for people with asthma;
- Breast cancer screenings;
- Cervical cancer screening; and
- Retinal eye exam for people with diabetes (currently only required of COHS plans).”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modifications.

The DHCS and MCOs may have difficulty implementing this recommendation due to the cost associated with obtaining a statistically significant sample (NCQA requires a 411 sample size). Although the services with the associated measures are important to the population, being served it may be difficult to achieve the required sample size. Of note: all plans are required to provide HEDIS data for retinal eye exams on members with diabetes.

The DHCS can pursue an examination of data to determine which measures could be most appropriate for this population. See findings for Recommendation 47, (PM-CR-2 where the DHCS may explore avenues other than HEDIS measures to collect and analyze similar data).

As previously stated privacy information concerns regarding stratifying data must be resolved, this will be completed via consultation with the DHCS Privacy Officer.

**CHCF Recommendation 47:** PM-CR-2, Priority 1 - Essential (contract change)

“MCOs shall collect the following HEDIS measures in addition to its EAS reporting requirements:

- Comprehensive Diabetes exam (retinal eye exam, HBA1c test, LDL screening and neuropathy screening);
- Antidepressant medication management;
- Controlling high blood pressure;
- Annual monitoring of patients on persistent medication;
- Cholesterol Management for patients with Acute Cardiovascular Conditions;
- Beta-blocker treatment after a heart attack; and
- Persistence of beta-blocker treatment after a heart attack.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to have a later implementation date due to significant fiscal and operational impact.

Adding new HEDIS measures to the current data set will require additional resources. In the absence of new funds, the DHCS could rotate new HEDIS measures into the twelve that are now measured and remove other measures to avoid increased costs. This is not feasible in the present time. The DHCS also uses five of its current measures for the default algorithm component of the Performance Based Auto-Assignment Project, effective December 2005, and does not plan to modify them in these early stages of implementation. Since HEDIS measures must be monitored over a period of time to evaluate improvement, annual rotations are not feasible nor NCQA supported. HEDIS

measures must be selected regarding their relevance and ability to be measured by the plans.

This recommendation not only adds HEDIS measures, but it also requires the data to be stratified for the SPD population, which would likely require over sampling of this population. The HEDIS measures are developed for conditions with well-established treatment protocols. Pursuit of this recommendation will require additional time for the DHCS to determine when and how the EQRO contract terms can be modified to accommodate this recommendation.

The DHCS may also explore other avenues other than HEDIS to collect and analyze this data.

**CHCF Recommendation 48:** PM-SR-1, Priority 2 - Important (state agencies)

“If no nationally tested measures that address the areas of focus identified by the performance measurement workgroup exist, then DHCS should expand the focus of the Medi-Cal Managed Care Division (MMCD) Quality Improvement Committee or create a new subcommittee that is charged with identifying measures that should be added. The group should include representatives from the MCO’s Quality Improvement Committees, people with disabilities and chronic conditions, and people with special expertise in measurement development and clinical issues related to people with disabilities and chronic conditions and state agencies with experience in quality reporting (e.g., Office of the Patient Advocate). DHCS should take a phased-in approach to identifying new measures. Within the next year, the committee should identify three new measures to pilot test in clinical or non-clinical priority areas such as:

Clinical Priority Areas:

- Screenings (e.g., depression and osteoporosis);
- Secondary conditions/complications in disabled people (e.g. urinary tract infections, skin ulcers/decubiti, osteoporosis, etc.);
- Obesity;
- Depression;
- Dental (care and prevention);
- Pain management;
- Identification of adequate treatment for high risk cases;
- Prevention and care of acute and chronic conditions;
- Care management and continuity of care; and
- Ambulatory Sensitive Conditions (as suggested by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ)).

Non-Clinical Priority Areas:

- Emergency Department use; and

- Access to and availability of services.

Based on the workgroup's findings, a small set of measures can be pilot tested by Medi-Cal MCOs (preferably COHS plans) prior to determining whether the measure should become a Medi-Cal required performance measure. Pilot tests also could be coordinated with Quality Improvement Projects required by Medi-Cal. The pilot tests and resulting data could be used to evaluate new approaches and to develop consensus-based guidelines."

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

The DHCS can engage the MMCD Quality Improvement Committee to address the issues and suggestions presented; however, implementation of new measures could require significant resources.

**CHCF Recommendation 49:** PM-SR-2, Priority 1 - Essential (state agencies)

"In year one, the DHCS, working with key stakeholders, should develop a standardized statewide consumer satisfaction survey tailored to identify issues important to people with disabilities and chronic conditions. The survey questions should build off the existing CAHPS surveys, but also address additional areas more specific to the needs of people with disabilities and chronic conditions (e.g., care coordination and DME)

Guidelines for administering the survey:

If feasible, prior to the roll out of expanded mandatory managed care for people with disabilities and chronic conditions, the DHCS should administer the survey in the FFS setting to establish baseline data that can be used for comparison purposes to future years in the managed care system.

Survey should be sent annually.

The survey methodology should be modified to allow members to use a proxy or alternative formats to complete the survey.

Stakeholder group:

The stakeholder group should have broad-based representation from DHCS, MCOs, advocacy groups, and providers/clinicians, groups with expertise in serving people with disabilities and chronic conditions, and measurement/survey experts.

Areas of emphasis for survey:

- Timeliness and access to PCP and/or specialist;
- Satisfaction with PCP and/or specialist;
- Access to pharmaceutical services;
- Durable medical equipment;
- Physical access/facility access;
- Care coordination; and
- Auxiliary communications (e.g. interpreters, alternative formats, etc.).

Guidelines for survey questions:

The questions used in the survey should lead to results that are measurable, actionable, meaningful, and applicable to people with disabilities and chronic conditions. In addition, wherever possible the survey should strive to address issues common to people with disabilities, chronic conditions, and the elderly.

The stakeholder group should use the surveys developed by CalOptima, Inland Empire Health Plan (IEHP), and other states as a basis for the new survey.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification to have a later implementation date contingent upon resources.

The DHCS does not have the expertise to develop an effective survey that could identify issues important to people with disabilities and chronic conditions.

The Agency for Health Research and Quality (AHRQ) is developing a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey model for people with mobility impairment that is still being tested. Once the AHRQ has completed the testing phase of their work, the DHCS will consider utilizing the survey tool. However, these types of surveys are costly and the DHCS will be limited to what it can accomplish with available funds.

A potential option may be to use the CalOptima and IEHP survey instrument, which has been developed specific to people with disabilities and chronic conditions. The DHCS will explore coordinating with these MCOs.

**CHCF Recommendation 50:** PM-SR-3, Priority 3 - Ideal (state agencies)

“DHCS should consider developing adequate financial and non-financial rewards to motivate MCOs to improve quality and overall performance. If a non-financial incentive approach is taken, then the DHCS should use such strategies as reducing administrative burden for MCOs meeting performance requirements or publicizing performance to reward the better performing MCOs.”

**DHCS response:** The DHCS agrees with the intent of this recommendation.

Non-financial incentives are currently used in the Medi-Cal Managed Care program including publication of a “consumer guide,” public reporting of HEDIS performance measures, public reporting of CAHPS survey results, and use of HEDIS performance measures in assignment of default enrollments.

The DHCS supports developing financial incentives to improve the MCOs’ performance; however, there are currently no new funds for this purpose. The DHCS will consider how it can incorporate financial incentives in future changes to its rate methodology and will consider development of alternative methods to reward MCOs for superior performance.

**COORDINATION OF CARVE-OUT SERVICES:** These recommendations are directed to the California Health and Human Services Agency and the California Legislature. These recommendations aim to ensure Medi-Cal beneficiaries benefit from seamless coordination between MCOs and carve-out service providers.

**CHCF Recommendation 51:** CCO-SR-1, Priority 1 – Essential (state agencies)

“The legislature should require the CHHSA departments with oversight of the carve-out service system to develop and execute a reciprocal, state-level, interagency MOU. Each department providing a carved-out service will be required to submit an annual MOU compliance report to the Legislature. The MOU should contain, at a minimum, the following provisions:

- **Coordinating Care Among Providers:** CHHSA departments with oversight of providers of carve-out services shall engage in on-going auditing activities of carve-out providers to ensure that the required level of coordination of care (as noted in the Local-Level MOU) is occurring;
- **Sharing Clinical Information:** CHHSA departments that contract with and have oversight of providers of carve-out services shall share with the MCO historical, member-level claims data regarding MCO enrollees who are receiving Medi-Cal funded carve-out services (as permitted by confidentiality laws and regulations) to ensure the MCO has the information to coordinate care across the carve-out system;
- **State-Level Accountability:** CHHSA departments that contract with and have oversight of providers of carve-out services must designate a staff person who is responsible for ensuring the provisions of the state-level MOU are followed; and
- **Responsibility for Paying for Services:** DHCS and CHHSA departments that contract with and have oversight of providers of carve-out services must develop a service matrix that lists all Medi-Cal funded carve-out services and notes the correct payer: MCO or appropriate carve-out provider (see “Clarify Payment Responsibilities Recommendation”).

The state legislature should review all state laws that restrict the sharing of health care-related information between state agencies and appropriate partners. If barriers are found, the legislature should explicitly allow the health care-related information to be shared among state agencies and appropriate partners.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modifications to the proposed vehicle to achieve the goal.

The DHCS agrees with the intent to improve coordination of carved-out Medi-Cal services. The DHCS could convene a work group comprised of all impacted state departments to explore ways to improve current processes and coordination. This would be accomplished under the authority of the California Health and Human Services Agency (CHHSA). The DHCS could begin the process by looking at coordination of carve-out services within the Department such as California Children’s Services. Lastly, the various carve-out programs may need statutory authority to share member-level data as the recommendation suggests.

**CHCF Recommendation 52:** CCO-SR-2, CO-SR-2, Priority 3 - Ideal (state agencies)

“CHHSA, in cooperation with the appropriate partners, shall develop a local level MOU that shall contain, but not be limited to, the following elements:

- Establish the Basic Elements of Care Coordination: Establish requirements for activities needed for coordination of carve-out services. This will ensure that each organization serving members in a carve-out system will have the same expectations for responsiveness. For example, the MOU should establish response time requirements for inquiries from carve-out system partners (e.g., any phone call about a shared member should be returned within 24 hours) and establish a process to inform carve-out system partners about the correct staff contacts (e.g., supply carve-out partners with updated contact lists of agency staff on a quarterly basis); and
- Interagency Team Development: Establish and delineate the responsibilities of a Local Interagency Team initiative designed to assist in coordinating care.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

The DHCS agrees with the goal of this recommendation; however, the DHCS must engage in substantial discussions with appropriate entities to achieve the goal of this recommendation and the intent of Recommendation 51, (CCO-SR-1, CO SR-1). Before local level coordination can be achieved, state level responsibilities must be identified. This task could be incorporated into the work group suggested in response to Recommendation 51 (CCO-SR-1, CO-SR-1).

**CHCF Recommendation 53:** CCO-SR-3, CO-SR-3, Priority 1 - Essential (state agencies)

“CHHSA shall identify and clearly delineate the appropriate party for claims payment”.

CHHSA should use the following mechanisms to communicate payment clarification:

**Service Matrix:** CHHSA shall develop and maintain a state-level internet-based service matrix that lists all carve-out services and notes the appropriate payer, MCO, or appropriate carve-out provider. The state should work with all appropriate partners in the development of the service matrix and should ensure that the information is widely distributed. The matrix shall be a part of the state-level MOU and be inserted into the MCOs’ and carve-out providers’ contracts to ensure all parties have clear direction on payment responsibilities (Note: the Western Center of Law and Disability is working with Inland Empire Health Plan on a similar project. The state could use the learning’s from this project as the foundation for its matrix).

**Website:** CHHSA shall develop and maintain a website designed to present policy clarifications specific to payment issues. The site should have an area designed to accept questions and post responses. The website should be open and available to anyone to review. The website would serve as a single information point for members, MCOs, and providers to access managed care and carve-out payment policy information.”

**DHCS response:** The DHCS agrees with the intent of this recommendation with modification.

The DHCS agrees with the fundamental elements and agrees that responsibility lies with the DHCS. The DHCS could utilize the work group (work group comprised of all impacted state departments to explore ways to improve current processes and coordination) suggested in response to Recommendation 51, (CCO-SR-1, CO-SR-1) in response to this recommendation.

## **Conclusion**

The CHCF recommendations are an excellent resource for the DHCS in its goal to improve access and quality of care for all Medi-Cal beneficiaries, particularly those living with disabilities and chronic health conditions. While there are challenges in implementing many of the CHCF recommendations, the DHCS intends to work with MCOs and advocates to develop strategies and milestones to implement appropriate performance standards in the Medi-Cal Managed Care program.

The DHCS has reviewed the recommendations and is identifying those that it can implement with existing resources in the immediate future. Many of the recommendations will require additional work and consultation with stakeholders before the Department can proceed while others will require similar effort and significant new resources. For these reasons, DHCS implementation of supported recommendations would take place over an extended period of time, contingent upon receipt of necessary resources, including appropriate rate adjustments for the contracted health plans.

DHCS Response to the CHCF Recommendations  
Summary of Public Comment

The Department Health Care Services (DHCS) Medical Managed Care Division (MMCD) response to the California Healthcare Foundations (CHCF) report entitled “Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions” was submitted for public review and comment on June 11, 2007 and closed for public comment on July 31, 2007.

There were fourteen respondents. The respondents comprised seven health plans/managed care organizations (MCOs), two children’s hospitals, one children’s coalition, one private individual, one private healthcare management corporation, one national public interest law firm and the CHCF “Project Team”.

The comments addressed support and reinforcement of policies and performance in the following areas:

- Access to data
- Care management and performance measurements and policies
- Children with disabilities and chronic illness need a separate process
- Children with disabilities and chronic illness should remain in CCS and in carve out services
- Children with disabilities and chronic illness need their own pilots and performance measurements
- Community based systems of care
- Costs to implement recommendations
- Coordination of carve out services
- Gaps in clinical guidelines/best practices
- Implementation of pilots
- Local Memorandums of Understanding (MOUs)
- Medical record transfer and coordination of care
- New measures/clinical and non clinical
- Performance measurements/SSI specific HEDIS measures
- Privacy and Personal Health information (PHI) and data
- Provider directory for provider access specific to the disabled
- Quality improvement and stratification of data
- Utilization of data and preventable hospitalizations
- Work groups with MCO participation

The comments received did not significantly change the Department’s response to individual recommendations; however, they will be useful to DHCS in its follow-up work as appropriate.