



CALIFORNIA
HEALTHCARE
FOUNDATION

Medi-Cal Health Plan Readiness Assessment Tool

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**Prepared for the
California HealthCare Foundation**

**Prepared by
The Lewin Group**

Introduction

In November 2005, the California HealthCare Foundation (CHCF) published “Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions.”¹ This report provides a set of recommendations designed to help California policymakers, Medi-Cal program officials, beneficiaries, and the public measure and improve the performance of the Medi-Cal managed care program. Establishing appropriate standards and measuring performance are essential to ensuring that beneficiaries with disabilities have access to high quality care and that the state is getting sufficient value for the billions of dollars paid to managed care plans for serving this population.

This Medi-Cal Health Plan Readiness Assessment Tool, which reflects the recommendations of the 2005 CHCF report, is designed to help state officials determine whether a health plan is prepared to enroll and serve a large number of beneficiaries with disabilities. It is intended to supplement the tools and activities the state already uses to assess the readiness of a health plan to serve Medi-Cal beneficiaries. This tool is not designed to be used alone, as it does not reflect existing performance standards and measures used in Medi-Cal managed care.

This tool has several potential uses. It can be used to help evaluate health plans that already enroll a large number of people with disabilities, such as current County Organized Health System (COHS) plans and certain local initiative and commercial plans in large counties. Also, in counties where enrollment in managed care becomes mandatory for Medi-Cal beneficiaries with disabilities – either because the county adopts a COHS or because the legislature approves an expansion of mandatory managed care for disabled beneficiaries in Two-Plan Model or Geographic Managed Care counties – this tool can be used to help assess the readiness of plans that must prepare to serve a large influx of new members with disabilities. In addition, the tool can be used by health plans or other stakeholders to assess the capacity to serve members with disabilities and to identify areas for operational enhancement, irrespective of which of the recommended performance standards the state might adopt.

Methodology

This tool draws upon The Lewin Group’s extensive experience assisting both states and health plans to effectively serve individuals with disabilities and chronic conditions. The basic readiness review methodology – to use a combination of document review and interviews to evaluate health plan operations against a defined set of criteria – has been tested in pre-operational readiness assessments and ongoing operational monitoring in many states.

The specific criteria in this tool reflect the recommendations provided in the 2005 report published by CHCF for performance standards and measures to be added to the contracts of health plans serving Medi-Cal beneficiaries with disabilities and chronic conditions. (Recommendations for state agencies are not addressed in this tool.) The CHCF report was developed by a team of consultants from the Center for Health Care Strategies, the Western University Center for Disability Issues and the Health Professions, and The Lewin Group. The recommendations are based on the consulting team’s review of existing practices in Medi-Cal and of the best practices in other states Medicaid programs and in the private sector. The

¹ Full report available at www.chcf.org/topics/medi-cal/perfstandards/index.cfm?itemID=116096.

recommendations also reflect feedback from an extensive stakeholder process that included nearly 200 consumers and consumer advocates, health plans and providers, state officials, and national experts.

For each recommendation, this tool provides suggestions for specific elements to assess and the documents to review and staff to interview to make the assessment. These suggestions are based on typical health plan organizational structure and the policies and functions most health plans use. There will be some variation among plans and the suggestions in this tool should be considered a starting point.

Using This Tool

The tool includes five questionnaires designed to assist evaluators in assessing how well a managed care organization (MCO) is able to provide services to members with disabilities and chronic conditions, according to the recommendations made in 2005:

- Member services (MS)
- Provider network (PN)
- Benefit management (BM)
- Care management (CM)
- Quality improvement and performance measurement (QI)

Each questionnaire outlines minimum qualifications for an MCO that provides services to people with disabilities and chronic conditions. Within each section of the questionnaire, the reviewer will assess each item to determine, once the entire section is reviewed, whether the MCO's written policies and procedures are compliant with the Medi-Cal contract requirements and whether they demonstrate understanding of California program expectations. The reviewer will also ask key MCO staff to explain MCO processes and ensure that the oral explanation is in line with the written policies and procedures.

Detailed instructions for preparing for each area of review (e.g., documents to collect, staff to interview) are provided at the beginning of each of the five sections, so that each section can be assessed individually. The format of each review section is similar, although some areas of review have a greater number of open-ended questions. In general, the reviewer should record answers in the boxes provided as well as any additional relevant information and comments.

For example, one recommendation regarding member services states that "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 MCO's 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."

To assess a plan's readiness to meet this objective, this tool recommends that a reviewer interview the Member Services director, member outreach/education director, HIPAA

compliance director, member advocate, and complaints and grievances coordinator. The reviewer would also obtain documentation such as MCO policies on member advocacy and job description(s) and resume(s) of staff functioning as the Medi-Cal member advocate. These would be reviewed to determine whether the MCO provides member advocacy support through a designated staff person, and if the advocate's responsibilities include the types of activities outlined in the recommendation.

For some elements, MCO readiness can be assessed through objective criteria: a policy or procedure is documented and staff is able to demonstrate through discussion or demonstration how they execute the policy or procedure. For example, a reviewer could assess whether a plan meets the requirement to use the relay service (711 or TTY) for people with speech disabilities and for the deaf by using a TTY device to contact the plan and following the plan's instructions to members, to ensure that plan staff on the other end of the line can respond appropriately. It may be more difficult to assess compliance with other elements, such as whether the MCO arranges for the provision of specialty services from specialists outside the network if unavailable within the MCO's network, when determined medically necessary. The MCO may have policies showing that it will do this, but reviewers may need to gather other evidence (such as utilization review decision logs) and interview staff to determine whether the plan is actually implementing the stated policy in a consistent manner that meets the spirit as well as the stated intention of the recommendation.

The review sheets also include space for reviewers to record the names, dates, and locations of source documentation (for future reference), comments on each section, and an overall assessment of the MCO's ability to provide services to the enrolled population. The overall assessment should include recommendations for the MCO on any items for which the reviewer did not find the answers to be satisfactory. These recommendations can form the basis for immediate corrective action, longer-term improvement goals, and ongoing monitoring recommendations.

Please note the following instructions for using the forms:

- An asterisk (*) in the gray columns indicates whether the reviewer should get the answer from a staff interview (**Int**) and/or from a written policy document (**Doc**).
- **Review Source(s)** allows the reviewers to record the source used for assessing the requirement (e.g., document title, policy title, and date).
- The **Compliant** column is where the reviewer should check **Yes** or **No** for each detailed item, indicating whether the health plan is compliant with the MCO contract requirements and state program expectations. Any items that are checked "no" should be addressed in the overall assessment.
- The **Comments/questions for follow-up** column allows space for notes regarding any additional follow-up that may be needed.

A sample blank review form and a sample completed review form are attached below.

Sample Blank Review Form

Notes on how to complete the form are in italics.

A. 1 General Quality Improvement Activities	Int	Doc	Reviewer Source(s)	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO tailors existing QI requirements and gathers information specific to people with disabilities/chronic conditions		*	<i>Note source used here</i>			<i>Note additional reviewer comments here specific to the item in this row</i>
2. MCO identifies gaps in care for people with disabilities/chronic conditions		*				

Additional Reviewer Questions:

- 1. What are your planned quality assurance activities relating to members with disabilities and chronic conditions?**

Some review areas can be assessed through open-ended questions for health plan staff. Note responses here.

Additional Information

Note additional reviewer comments here related to the topic.

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Provide a summary assessment of the review area. Explain any “no” items and how the MCO should address these items.

Sample Completed Review Form

Sample review information is in italics.

A. 1 General Quality Improvement Activities	Int	Doc	Reviewer Source(s)	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO tailors existing QI requirements and gathers information specific to people with disabilities/chronic conditions		*	<i>QI program description for 2007 (page 15)</i>	X		
2. MCO identifies gaps in care for people with disabilities/chronic conditions		*	<i>QI program description for 2007</i>	X		<i>MCO conducts quarterly data reviews and also monitors requests through Member Services hotline</i>

Additional Reviewer Questions:

- 1. What are your planned quality assurance activities relating to members with disabilities and chronic conditions?**

The MCO described a robust review process that includes quarterly reviews of data, stratified for members with disabilities and chronic conditions. The MCO supplements these reviews with annual telephonic member satisfaction surveys, with a specific emphasis on the experience of members with disabilities. The Member Services department also monitors member requests and provides ongoing updates to the QI staff. The MCO also monitors the experience of members before and after participating in disease management programs.

Additional Information

The MCO provided evidence of a commitment to continuous quality improvement processes, including periodic data reviews and presentations to its board of directors.

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Although the MCO has a comprehensive quality improvement program, it appears to lack cohesiveness and overall goals. For example, the disease management programs capture good information, but are limited to members with congestive heart failure, diabetes, and hypertension. Also, although efforts are in place to assess the experience of members with disabilities, these efforts are relatively new and the MCO has not had the time to demonstrate that the results can actually result in improved quality. The MCO should consider adding to its existing programs while continuing to work to improve quality and measure outcomes over the next year.

Member Services Review Tool

The attached questionnaire is designed to assist an evaluator in assessing the MCO's member services available to people with disabilities and chronic conditions. The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation.

The questions are grouped into four categories:

- A. Member Services Staffing and Training** includes high level requirements for staffing and training, and determines how the MCO addresses issues pertaining to disabilities in its staffing and training practices.
- B. Member Materials and Web Sites** assesses how the MCO will make member materials and its web site accessible to members with disabilities.
- C. Provider Transition at Enrollment** reviews how the MCO will ensure that members with disabilities are appropriately transitioned into managed care.
- D. Medi-Cal Member Advocacy** evaluates how the MCO will ensure that the needs of members with disabilities are advocated for within the organization.

Items to Review

The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation. Written documents will be examined to ensure that they are compliant with the policies set forth by the Medicaid program. Written documents to be reviewed include the MCO contract and, at a minimum:

- Policies on member services staff training, including cultural competency
- Job descriptions and resumes of member services staff
- Policies on communicating with members with disabilities
- Policies on providing member materials in alternate formats
- Policies on transitioning members to an in-network provider upon enrollment
- Job description(s) and resume(s) of staff functioning as Medi-Cal member advocate
- Policies on member advocacy, including coordination internally and with external advocates

Reviewers should supplement the policy and procedure review with interviews (in person or by phone) with MCO staff. These interviews will ensure that qualified staff are aware of and able to implement the written policies and procedures. Staff to interview include, at a minimum:

- Member Services director
- Member outreach/education director
- HIPAA compliance director
- Member advocate
- Complaints and grievances coordinator

Topic:	A. Member Services Staffing and Training
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Member services staff hiring plans, policies on member services staff training, including cultural competency, member services department policies and procedures, job descriptions and resumes of member services staff, policies on communicating with members with disabilities	

Background

The process of enrolling new members in managed care organizations and providing them with the information needed to navigate the system, both at enrollment and on an ongoing basis, are critical functions for the state, enrollment broker, MCOs, and enrollees. It is important that beneficiaries are supported as they transition from the fee-for-service program into managed care. The managed care program uses different mechanisms than the fee-for-service system for choosing a physician, obtaining approval for care, getting assistance in coordinating care, and accessing accommodation or other support services. In particular, MCOs must ensure that the move from FFS to managed care does not disrupt people's existing and critical network of services. This is the primary concern of people with disabilities and chronic conditions.

The member services function is crucial because most members call the general member services number whenever they have a question and expect to get answers in a timely, competent manner. However, providing assistance to members with disabilities and chronic conditions may require a different set of skills than those currently used for the Temporary Assistance to Needy Families (TANF) populations. Staff training serves as a foundation necessary to ensure that people with disabilities and chronic conditions are able to access timely and appropriate services.

A.1. Member Services Functions Review Goal: Review should determine whether the MCO has a fully-functional member services department that provides essential member services.

A.1. Member Services Functions	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has a member services department that is responsible for the following activities:	*	*		___	___	___
a. New member orientation		*				
b. PCP selection and assignment		*				
c. Facilitating individual and group needs assessments		*				
d. Distributing member materials		*				
e. Notifying members of rights and responsibilities		*				

Reviewer Comments:

The reviewer should note whether the MCO has tasked a different department with responsibility for any of these activities

A.2. Staffing and Training Review Goal: Review should determine that MCO staff are adequately qualified and trained on pertinent issues including cultural competency, diversity, and sensitivity.

A.2. Staffing and Training	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides member services to Medi-Cal members through sufficient assigned and knowledgeable staff	*	*				
2. MCO ensures member services staff are trained on all contractually-required member services functions including, policies, procedures, and scope of benefits covered by the MCO	*	*				
3. Training on scope of benefits includes carve-out services and how to refer people to services covered by other state agencies	*	*				
4. MCO provides member services staff with training on cultural competency, sensitivity, or diversity that includes information about:	*	*		_____	_____	_____
a. The identified cultural groups in the MCO's service areas (e.g., the groups' beliefs about illness and health)	*	*				
b. Methods of interacting with providers and the health care structure	*	*				
c. Traditional home remedies that may impact what the provider is trying to do to treat the patient	*	*				
d. Language and literacy needs	*	*				
e. Various types of chronic conditions and disabilities prevalent among Medi-Cal beneficiaries	*	*				
f. The types of barriers that adults with physical, sensory, and communication disabilities or developmental or mental health needs face in the health care arena and the resulting access and accommodation needs	*	*				
g. The essential principles of quality care in treating people with disabilities/chronic conditions	*	*				

A.2. Staffing and Training	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
Reviewer Comments:						

Additional Reviewer Questions:

1. How often are health plan staff trained on cultural competency?

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	B. Member Materials and Web Sites
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Calendar/ schedule of education activities, policies on providing member materials in alternate formats, sample member materials in alternative formats, member services department policies and procedures, Web site	

Background

States that enroll people with disabilities or chronic illness on a mandatory basis typically have information on the plan operations and services that are of particular interest to people with complex or chronic health needs (e.g., care management). This information is contained in the handbooks that are distributed to all members.

The current Medi-Cal contract requires MCOs to provide all new Medi-Cal members with written member information, including a member services guide. The guide must meet certain regulations regarding print size, readability, and ability of text to be understood. The contract also requires that all written information must be at a sixth grade reading level and translated into the identified threshold and concentration languages. In addition, MCOs must make the member services guide available in alternate formats upon request. The contract also requires MCO Web sites to be accessible to people with disabilities.

B.1. Alternate Formats Review Goal: Review should determine how the MCO provides written materials in alternative formats for members with special needs.

B.1. Alternate Formats	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides examples of written member materials in alternative formats, including Braille, large size print, and audio format		*				
2. MCO provides written materials in alternative formats in a timely fashion upon request to members (e.g., 7 days)	*	*				
3. MCO has a process to convert all materials to alternative formats when requested by a member	*					
4. MCO has a process for a member to make a standing request for all materials to be provided in a specified alternative format	*					
Reviewer Comments:						

B.2. Communication Review Goal: Review should determine how members with disabilities will communicate with the member services department and how they will receive member materials.

B.2. Communication	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a mechanism for members who are deaf to communicate with the member services department staff	*	*				
2. MCO has a mechanism for members who are deaf to obtain assistance in scheduling and attending appointments	*	*				
3. MCO has a mechanism for members who have one or more physical, mental, or developmental disabilities, including blindness, to receive member materials	*	*				
4. MCO has a mechanism for all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries to receive 24-hour oral interpreter services at all key points of contact, either through interpreters or telephone language services	*	*				
Reviewer Comments:						

B.3. Web Site Review Goal: Review should determine how the MCO ensures its web site is accessible to members with disabilities.

B.3. Web Site	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a Web site that is accessible to members with disabilities.	*	*				
a. Web site is formatted to work with "screen readers" used by people with visual disabilities		*				
b. Web site's use of color does not limit users with reduced color sensitivity from accessing information		*				

B.3. Web Site	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
c. Web site provides alternative means of communicating audio information (e.g., transcripts or captions)		*				
Reviewer Comments:						

Additional Information

1. How are member education materials oriented to various groups within the managed care population, including people with disabilities, the elderly, children, and non-English speaking members? (e.g., alternative formats and languages)

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	C. Provider Transition at Enrollment
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies and procedures related to transitioning members to in-network providers upon enrollment	

Background

The process of enrolling new members in managed care organizations and providing them with the information needed to navigate the system both at enrollment and on an ongoing basis is critically important. Continuity of care is particularly important for people with chronic conditions or disabilities who may have long-term relationships with specific providers and ongoing courses of treatment. As such, the MCO should make efforts to ensure that the transfer into managed care does not disrupt people's existing network of care. Transfer of members' care is important in the event the MCO contract is terminated or if a provider leaves the MCO network, as well as during the transition to managed care from fee-for-service. Most MCOs already work with members on a case-by-case basis to transition them from the care of one provider to another, in some cases for as long as six months.

C.1. Transition Policies and Procedures Review Goal: Review should determine whether the MCO provides members adequate assistance in transitioning to MCO providers, and how the MCO assists in coordination of care during the transition period.

C.1. Transition policies and procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO describes how it works with fee-for-service providers (for people newly enrolled in managed care) or other MCOs (for people switching between MCOs) to ensure that:	*	*				
a. An ongoing course of treatment (including prescriptions and DME) is not interrupted or delayed due to the change to new providers	*	*				
b. Medical record information is transferred to new providers in a timely fashion	*	*				
c. The transition from a non-network fee-for-service provider to a network provider is accomplished within 60 days (to the extent possible)	*	*				
d. If a member transitions from the MCO to another MCO or back to the fee-for-service system, the MCO provides assistance in coordinating referrals and transitioning medical records.	*	*				

C.1. Transition policies and procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
Reviewer Comments:						

Additional Information

1. **Are there exceptions to the transition process for women who are in their third trimester of pregnancy?** (*Note: More detail on Network Review Tool*)

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	D. Medi-Cal Member Advocacy
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies on member advocacy, including coordination internally and with external advocates, Job description(s) and resume(s) of staff functioning as Medi-Cal member advocate	

Background

Member advocacy is an important health plan function, since many people with disabilities and chronic conditions have significantly different needs than the general population. California MCOs have a contractual responsibility to provide assistance to members in navigating the managed care system through a general member advocacy function. This includes coordinating with external advocates and within MCO departments. The member advocate will be a staff member with additional training and responsibilities focused on the needs of members with disabilities and chronic conditions, and serves as a link between members and the MCO management.

D.1. Member Advocacy Policies Review Goal: Review should determine whether the MCO provides member advocacy support through a designated staff person, and if the advocate’s responsibilities include working with relevant internal and external organizations.

D.1. Member advocacy policies	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a policy for providing support to beneficiaries with disabilities/chronic conditions		*				
a. This policy includes responsibility for assisting members with complaint and grievance resolution		*				
b. This policy includes responsibility for investigating and resolving access and disability competency issues		*				
2. MCO has a designated staff person with responsibility for overseeing disability-related issues	*	*				
a. The staff person’s responsibilities include monitoring compliance with the MCO’s Americans with Disabilities Act compliance plan	*	*				
b. The staff person’s responsibilities include functioning as a contact for beneficiary advocacy groups	*	*				

D.1. Member advocacy policies	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
c. The staff person's responsibilities include working with beneficiary advocacy groups to identify and correct the beneficiary's access barriers	*	*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)

Provider Network Review Tool

The attached questionnaire is designed to assist an evaluator in assessing the adequacy of the provider network to provide services to people with disabilities and chronic conditions. The review will require a mix of document review and interviews with MCO staff to assess the various operational areas. This assessment covers the accessibility of providers for members with physical limitations or disabilities.

The questions are grouped into six categories:

- A. General Network Analysis** contains high-level requirements for the MCO (more detailed questions are included in the accompanying review sheets).
- B. Provider Network Adequacy Requirements** reviews the state's requirements for the types and ratio of providers to members.
- C. Medical Home Requirements** evaluates requirements for care coordination activities for primary care providers.
- D. Facility Site Review** assesses information on the Department of Health Care Services (DHCS; formerly the California Department of Health Services or CDHS) Facility Site review tool as well as elements related to member education about accessibility and provider training on disability competency.
- E. Accommodation Policies** determines compliance with requirements for provider accessibility, including office accessibility and phone access, and also includes requirements for publishing accessibility information in the provider directory.
- F. MCO Reporting ADA Accessibility Plan** reviews elements that should be included in the MCO's annual accessibility plan.

Items to Review

The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation. Written documents will be examined to ensure that they are compliant with the policies set forth by the Medicaid program. Written documents to be reviewed include the MCO contract and, at a minimum:

- Policies and procedures on maintaining adequate on member-provider ratios
- MCO network analysis for different provider types
- Policies and procedures related to ensuring the physical accessibility of provider offices; MCO's ADA accessibility plan
- Provider training materials related to disability cultural competency

Reviewers should supplement the policy and procedure review with interviews (in person or by phone) with MCO staff. These interviews will ensure that qualified staff are aware of and able to implement the written policies and procedures. Staff to interview include, at a minimum:

- Provider network/Provider relations director
- Credentialing manager

- Medical Director

Topic:	A. Network Analysis General
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Provider network monitoring procedures and reports to ensure adequate member-provider ratios, description of the provider network development process, maps or other internal provider network analysis displaying locations of providers, by type, relative to members	

Background

One of the key differences between the Medi-Cal fee-for-service program and the Medi-Cal managed care program is the use of physician networks. Unlike the FFS program, which allows beneficiaries to see any provider who participates in Medi-Cal, MCOs generally limit access to a pre-selected, credentialed network of providers. Because people with disabilities and chronic conditions may have existing relationships with providers with the appropriate clinical knowledge and disability competency, the composition and adequacy of the managed care provider networks is important.

The MCO will have a method in place to attempt to contract with members' physicians who are not in the MCO network.

A.1. Building an Appropriate Network of Providers: Review should determine whether the MCO has a network with the appropriate number and mix of providers.

A. 1 Building a Provider Network	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has an ongoing process to monitor the number and mix of providers in its network	*	*				
2. MCO looks at historical PCP use data to identify appropriate number and mix for the network		*				
3. MCO looks at historical specialist data to identify appropriate number and mix for the network		*				
4. MCO looks at historical hospital data to identify appropriate number and mix for the network		*				
Reviewer Comments:						

A.2 Monitoring Provider Network Composition: Review should determine whether the MCO has a process in place to ensure that members have geographic access to a range of providers.

A. 2 Monitoring Provider Network Composition	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has a process to monitor the number and mix of providers in its network	*	*				
2. MCO ensures access to primary care services, including obstetrics/gynecology, for its members within a reasonable distance of their places of residence	*	*				
3. MCO ensures access to specialty care services for its members within a reasonable distance of their places of residence	*	*				
4. MCO ensures access to pharmacy services for its members within a reasonable distance of their places of residence	*	*				
Reviewer Comments:						

A.4 Transitioning Members to Network Providers: Review should determine whether the MCO has a process in place to transition members to network providers.

A. 3 Transitioning Members to Network Providers	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO coordinates out-of-network services for new members as they identify and transition to new providers		*				
2. MCO communicates with members who seek care from out-of-network providers	*	*				
3. MCO communicates with out-of-network providers who provide care to members who are transitioning to the MCO's provider network	*	*				
Reviewer Comments:						

Additional Reviewer Questions:

1. If the MCO is moving into a new service area, how will the network be built?
2. What kinds of standards does the MCO have for various provider types (e.g., ratios and mileage standards)?
3. How does the MCO monitor provider access and mix on an ongoing basis? (e.g., monthly GeoAccess analysis)
4. What is the MCO's process for developing transition plans for members?

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)

Topic:	B. Provider Network Adequacy Requirements
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Provider network monitoring procedures and reports, maps displaying locations of providers, by type, relative to members	

Background

MCOs generally limit access to a pre-selected, credentialed network of providers. DHCS might establish provider network adequacy standards for MCOs to ensure access for members. Specific provider network adequacy standards might vary depending on a number of factors. If DHCS developed specific standards for a network that will serve members with disabilities/chronic conditions, these standards could be assessed through this part of the tool.

B.1. Review Goal: TBD

B. 1	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. To be added based on Medi-Cal requirements						
Reviewer Comments:						

Additional Reviewer Questions:

- 1. What are the most significant gaps in the MCO's provider network and how will the MCO serve members as these are being addressed?**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	C. Medical Home Requirements
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Sample provider contract for primary care physicians, policies and procedures related to the medical home	

Background

The MCO should provide a "medical home" for members with disabilities or chronic conditions, including having the PCP assess a patient's needs for specialty referrals and coordinate with specialists after referrals are made. Medi-Cal MCOs should be flexible while working with members and their families to identify nontraditional mechanisms of establishing a medical home. An example would be allowing the member to choose a primary care provider in a traditional PCP specialty (e.g., internal medicine), but allowing a standard referral to a key specialist who will work closely with the PCP to coordinate the member's care. The arrangement should value a medical home, but should modify the role of the specialist and PCP so that the member continues to be at the center of a care coordinated model.

C.1. Medical Home Requirements Review Goal: Review should determine whether the MCO has an appropriate process in place to ensure that members have a medical home.

C. 1 Medical Home Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a process for allowing a specialist to perform PCP functions, as needed	*	*				
2. MCO provides training for PCPs about their role as the member's medical home	*	*				
3. MCO monitors PCP patient loads and open/closed panels	*	*				
Reviewer Comments:						

Additional Reviewer Questions:

- 1. How does the plan monitor individual PCP patient loads and open/ closed panels? (e.g., monthly reviews and reports)**

- 2. What is the process for a specialist to take on the role of a PCP? (e.g., request through Provider Services Department)**

- 3. How does the MCO monitor wait times for appointments? (e.g., periodic surveys)**

- 4. How does the MCO monitor that providers are available 24 hours per day/7 days per week? (e.g., after hours calls)**

- 5. How are PCPs (including specialists serving as PCPs) trained on the concept of the “medical home”?**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	D. Provider Accessibility
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies and procedures related to ensuring the physical accessibility of provider offices, member and provider education materials related to accessibility, staff training materials related to provider accessibility and disability cultural competency	

Background

The MCO should identify areas of provider accessibility for members with disabilities and chronic conditions, using the DHCS-enhanced Facility Site Review tool, along with additional information related to physical and nonphysical accommodations. The MCO shall make this information available to members through member services materials.

The MCO should provide training or educational materials to its own staff and provider office staff regarding access problems faced by people with disabilities and how they can be ameliorated.

D.1. General Facility Site Accessibility Requirements Review Goal: Review should determine whether the MCO monitors accessibility of provider offices on behalf of members with disabilities and chronic conditions.

D. 1 General Accessibility Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO assesses PCP accessibility at individual provider offices and facilities	*	*				
2. MCO provides information on accessibility in the following areas:	*	*		_____	_____	_____
a. Building walkway/access	*	*				
b. Parking	*	*				
c. Reception/waiting area	*	*				
d. Exam room	*	*				
e. Restrooms	*	*				
f. Accessible scales	*	*				
g. Exam table	*	*				
h. Auxiliary aides and services	*	*				
i. Public transportation access	*	*				
3. MCO uses the DHCS-enhanced Facility Site Review tool, along with additional information related to physical and nonphysical accommodations	*	*				

D. 1 General Accessibility Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
4. MCO uses the Facility Site Review tool for providers other than PCPs. Please list: _____ _____ _____	*	*				
Reviewer Comments:						

D.2. Member Education About Accessibility Review Goal: Review should determine whether the MCO makes information available to members about accessibility of provider offices.

D. 2 Member Education About Accessibility	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides information on accessibility of individual provider offices on its Web site		*				
2. MCO provides information on accessibility of individual provider offices in the member handbook		*				
3. MCO provides information on accessibility of individual provider offices in the provider directory		*				
4. The provider directory includes the following elements:		*		_____	_____	_____
a. Information on PCP physical access		*				
b. Information on PCP communication access (e.g. availability of interpreters)		*				
c. Information on PCP telephone access		*				
d. Information on specialist physical access		*				
e. Information on specialist communication access		*				
f. Information on specialist telephone access		*				

D. 2 Member Education About Accessibility	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
g. Information on ancillary provider physical access		*				
h. Information on ancillary provider communication access		*				
i. Information on ancillary provider telephone access		*				
5. MCO provides information on accessibility of individual provider offices upon request through the member services hotline		*				
Reviewer Comments:						

D.3. MCO Staff Training on Disabilities Review Goal: Review should determine whether the MCO requires disability competency training for its employees.

D. 3 MCO Staff Training on Disabilities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO requires disability literacy and competency training for its employees, including information about the following:	*					
a. Various types of chronic conditions prevalent among Medi-Cal beneficiaries	*					
b. Awareness of personal prejudices	*					
c. Legal obligations to comply with the Americans with Disabilities Act		*				
d. Scope of benefits, including 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 PCPs	*					
e. Definitions and concepts such as communication access, medical equipment access, physical access, and access to programs	*					

D. 3 MCO Staff Training on Disabilities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
f. Types of barriers that adults with physical, sensory, communications disabilities, developmental or mental health needs face in the health care arena and the resulting access and accommodation needs	*					
2. MCO requires and provides training on accessibility rights for its employees		*				
3. Please list other staff competency training offered by the MCO: _____ _____ _____ _____	*	*				
Reviewer Comments:						

D.4. Provider Staff Training on Disabilities Review Goal: Review should determine whether the MCO provides disability competency education and training for its participating providers and their staff.

D. 4 Provider Staff Training on Disabilities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO educates providers on disability competency	*					
2. MCO includes articles on disability competency in provider newsletters		*				
3. MCO staff discuss disability competency with provider office staff on office visits	*					
4. MCO provides information on disability competency in its provider manual		*				
5. MCO provides information on disability competency on its Web site/ provider portal		*				

D. 4 Provider Staff Training on Disabilities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
6. Please list other disability competency education/training offered by the MCO for providers: _____ _____ _____ _____	*	*				
Reviewer Comments:						

Additional Reviewer Questions:

1. How frequently does the MCO conduct disability literacy and competency training for MCO staff and providers?

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	E. Accommodation Policies
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies and procedures related to accommodation, telephone access policies and procedures	

Background

The MCO should have policies and procedures in place describing how it will enable members to access services. The MCO provider directory should include information on accessibility, including accessibility of specialty/ ancillary providers and services, and be provided to members upon request. The MCO should also use a telephone 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.

E.1. Accommodation Policies Review Goal: Review should determine whether the MCO's policies and procedures address the accessibility needs of members with disabilities and chronic conditions.

E. 1 Accommodation Policies	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO's policies and procedures address the following elements to enhance access for people with disabilities/chronic conditions:		*		_____	_____	_____
a. Lifting policy and procedure		*				
b. Flexible appointment time and length		*				
c. Provision of service in alternative locations		*				
d. Use of identified facilitators (i.e., for members unable to express their needs)		*				
Reviewer Comments:						

E.2. MCO Telephone Access Requirements Review Goal: Review should determine whether the MCO uses certain telephone services available for members with disabilities and chronic conditions.

E. 2 MCO Telephone Access Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO uses a process for triaging member calls	*					
2. MCO has a service for providing telephone medical advice	*					
3. MCO has a process for members to access interpreters when necessary	*					

E. 2 MCO Telephone Access Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
4. MCO uses a telephone relay service (711 or TTY)		*				
5. MCO has a physician or other appropriate licensed professional available for after-hours calls		*				
Reviewer Comments:						

Additional Reviewer Questions:

1. How does the MCO identify members that need special accommodation (e.g., question included in health risk assessment)

2. How does the MCO work with providers to ensure that their offices are accessible? (e.g., annual surveys, on-site visits)

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	F. MCO Reporting ADA Accessibility Plan
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: ADA accessibility plan, organization chart displaying person responsible for the MCO's ADA accessibility plan	

Background

An annual MCO accessibility plan is a vehicle for health plans and DHCS to review continual improvements in plan operations to comply with the Americans with Disabilities Act. The plan provides MCOs the opportunity to set improvement goals and outline activities undertaken to meet them. The accessibility plans should be made public to promote transparency of information and to share such information with a broader group of stakeholders (e.g., consumers, providers, and other state officials).

F.1. General ADA Accessibility Plan Requirements Review Goal: Review should determine whether the MCO's ADA Accessibility Plan addressed the unique needs of members with disabilities and chronic conditions.

F. 1 General ADA Accessibility Plan Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has developed an ADA accessibility plan		*		---	---	---
2. The ADA accessibility plan is updated annually	*	*				
3. The ADA accessibility plan is made public and posted on the MCO's Web site		*				
Reviewer Comments:						

F.2. ADA Accessibility Plan Elements Review Goal: Review should determine whether the MCO's ADA Accessibility Plan includes certain required elements.

F. 2 ADA Accessibility Plan Elements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO's ADA accessibility plan includes the following elements:				---	---	---
2. Goals, priority activities, and resources for increasing accessibility to the services and activities of all MCO providers for members with disabilities/ chronic conditions		*				

F. 2 ADA Accessibility Plan Elements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
a. Goals related to aspects of accessible health care (e.g., disability literacy and competency training for MCO member services staff and health care providers)		*				
b. Goals related to aspects of accessible health care (e.g., ongoing identification of existing physical, equipment, communication, transportation, and policies/procedures barriers encountered by MCO members with disabilities/chronic conditions)		*				
c. Goals related to aspects of accessible health care (e.g., strategies for removing the identified barriers)		*				
d. Goals related to aspects of accessible health care (e.g., gathering and incorporating feedback from consumers with disabilities/chronic conditions)		*				
3. A process for the MCO to develop, track, and report on a list of key indicators to track progress toward plan goals		*				
4. Identification of staff responsible for coordinating the implementation of the accessibility and accommodation goals		*				
5. Information on the disability literacy and competency training provided to member services staff (e.g., training schedule, content)		*				
6. Organizational chart showing the key staff people/positions who have overall responsibility and/or practical responsibility for implementing the accessibility and accommodation goals		*				
7. Narrative explaining the organizational chart and description of the oversight and direction		*				

F. 2 ADA Accessibility Plan Elements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
8. Summary report of data regarding complaints and grievances related to people with disabilities/chronic conditions		*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Benefit Management Review Tool

The attached questionnaire is designed to assist an evaluator in assessing the ability of the MCO to appropriately manage benefits for people with disabilities and chronic conditions. The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation.

The questions are grouped into six categories:

- A. Utilization Management Program** contains high-level requirements for the MCO's utilization management program.
- B. Criteria Used to Make Review Decisions** evaluates how the MCO uses determination of medical necessity and scientific evidence to make coverage decisions.
- C. Qualifications of Reviewers** reviews how the MCO ensures that qualified staff make review decisions.
- D. Authorization of Out-of-Plan Services** assesses how the MCO ensures that members can access out-of-plan services when medically necessary.
- E. Patient Appeals/Provider Appeals** determines whether the MCO has a patient and provider appeal process in place that meets all requirements and is accessible to members with disabilities.
- F. Delegation** determines whether the MCO has sufficient delegation oversight in place.

Items to Review

The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation. Written documents will be examined to ensure that they are compliant with the policies set forth by the Medicaid program. Written documents to be reviewed include the MCO contract and, at a minimum:

- Written criteria or guidelines for utilization review and established definitions of medical necessity
- Utilization management policies and procedures
- Policies on out-of-plan service authorization and availability
- Coverage policies and requests for new technology and investigational treatments
- Copies of denial letters and other utilization management communications to members and providers
- Job descriptions and resumes of utilization management program staff
- Appeals policies and procedures, including notification, timelines, and communicating with members with disabilities
- MCO subcontracts and delegation oversight policies and procedures

Reviewers should supplement the policy and procedure review with interviews (in person or by telephone) with MCO staff. These interviews will ensure that qualified staff are aware of and able to implement appropriate written policies and procedures. Staff to interview include, at a minimum:

- Medical director
- Utilization Management director
- Review nurse supervisor

Topic:	A. Utilization Management Program
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Utilization management policies and procedures, prior authorization and other service authorization policies, coverage policies and requests for new technology and investigational treatments, copies of denial letters and other utilization management communications to members and providers	

Background

MCOs must develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. Utilization management programs allow the health plan to make decisions about medical care based medical necessity. Plans will use nationally recognized clinical guidelines when possible. For new or emerging services or technologies, the MCO’s Medical Director may convene a committee composed of participating providers to assist with making coverage determinations.

A.1. General Utilization Management Requirements Review Goal: Review should determine whether the MCO has a utilization management program that includes all key functions and uses established review criteria.

A.1. General Utilization Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
a. MCO has a written description of its utilization management program.		*				
b. UM program description includes procedures to evaluate the need for medically necessary covered services		*				
c. UM program description defines the clinical review criteria used, information sources, and process used to review and approve the provision of covered services		*				
d. UM program description establishes criteria for approving, modifying, deferring, or denying requested services. MCO uses these criteria and standards to approve, modify, defer, or deny services		*				
e. UM program description describes mechanisms to detect both under- and over-utilization of health care services		*				
f. UM program description includes the method for periodically reviewing and amending the UM clinical review criteria		*				

A.1. General Utilization Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
g. UM program description identifies the staff position functionally responsible for the day to day management of the UM function		*				
1. The MCO provides evidence of the following:	*			---	---	---
h. Qualified staff are responsible for the UM program		*				<i>Note: See also Section C, Qualifications of Reviewers</i>
i. Separation of medical decision-making from fiscal and administrative management	*					
j. A process to obtain a second opinion from a qualified health professional at no cost to the member		*				
k. Providers involvement in the development and or adoption of specific criteria used by the MCO	*	*				
l. Procedures for communicating to health care practitioners the procedures and services that require prior authorization and ensuring that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services (e.g. periodic training, provider newsletters)		*				
m. An established specialty referral system to track and monitor referrals requiring prior authorization through the MCO, including authorized, denied, deferred, or modified referrals, and the timeliness of the referrals, and non-contracting providers		*				
n. Procedures for ensuring that all contracting health care practitioners are aware of the referral processes and tracking procedures (e.g. periodic training, provider newsletters)		*				

A.1. General Utilization Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
o. A process for integrating UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff	*	*				
p. Procedures for obtaining all necessary information, including pertinent clinical information, and consulting with the treating physician as appropriate in making UM determinations		*				
Reviewer Comments:						

A.2. Prior Authorization/ Concurrent Review/ Retrospective Review – Review Goal: Review should determine whether the MCO’s review policies and procedures meet minimum requirements for staffing, communication, timeliness, and notification.

A.2. Prior Authorization/ Concurrent Review/ Retrospective Review	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. Qualified health care professionals supervise review decisions and a qualified physician reviews all denials		*				
2. Qualifications for staff who review decisions are delineated	*	*				
3. MCO has a process for evaluating consistency of review decisions	*	*				
4. MCO has a process for reviewing and updating utilization review criteria, including timeliness	*	*				
5. MCO documents reasons for review decisions and reviews these reasons periodically		*				
6. MCO describes how members with communication impairments are appropriately informed	*	*				
7. MCO has a well-publicized member appeals procedure		*				

A.2. Prior Authorization/ Concurrent Review/ Retrospective Review	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
8. MCO has a well-publicized provider appeals procedure						
9. MCO has a process for making decisions and appeals in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services		*				<i>Note: See also Section A.3, Service Authorizations</i>
10. MCO has a process for ensuring prior authorization requirements are not applied to the following services:		*		_____	_____	_____
a. Emergency services		*				
b. Family planning services		*				
c. Preventive services		*				
d. Basic prenatal care		*				
e. Sexually transmitted disease services		*				
f. HIV testing		*				
11. MCO has a policy that ensures records, including any Notice of Action, meet the DHCS retention requirements		*				
12. MCO describes how it notifies the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	*	*				
13. MCO provides sample of oral or written notification to the requesting provider						
Reviewer Comments:						

A.3. Service Authorizations Review Goal: Review should determine whether the MCO performs service authorizations within the required timeframe, as determined by the type of service.

A.3. Service Authorizations	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
MCO provides evidence that the following authorization timeframes are met:		*		_____	_____	_____
1. <u>Emergency care</u> : No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency		*				
2. <u>Post-stabilization</u> : Response to request within 30 minutes or the service is deemed approved		*				
3. <u>Non-urgent care following an exam in the emergency room</u> : Response to request within 30 minutes or deemed approved		*				
4. <u>Concurrent review of authorization for treatment regimen already in place</u> : Within five (5) working days or less, consistent with urgency of the member's medical condition		*				
5. <u>Retrospective review</u> : Within 30 calendar days		*				
6. <u>Pharmaceuticals</u> : 24 hours on all drugs that require prior authorization		*				

A.3. Service Authorizations	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
<p>7. <u>Routine authorizations</u> (e.g., requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization):</p> <p>Five (5) working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or the MCO can provide justification upon request by the state for the need for additional information and how it is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.</p>		*				
<p>8. <u>Expedited authorizations</u> (e.g., requests in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function):</p> <p>Three (3) working days after receipt of the request for service. The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the MCO can provide justification upon request by the state for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.</p>		*				
<p>9. <u>Hospice inpatient care</u>: 24-hour response</p>		*				

Topic:	B. Criteria Used to Make Review Decisions
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Utilization review guidelines and criteria, established definitions of medical necessity	

Background

A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. The interventions should assist in achieving, maintaining, or resorting health and functional capabilities without discrimination to the nature of the condition.

Interventions should also be known to be effective in improving health outcomes (can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects), and reflect current bioethical standards. Interventions are not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or series of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

MCOs have been required to have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, consistently applied, regularly reviewed, and updated. MCOs should have specificity regarding the coverage of investigational treatments and the process by which MCOs assess the appropriateness of new treatments and technologies. This is particularly relevant for members with disabilities and chronic conditions, who may be more likely to seek coverage of new treatments.

The written description of the coverage determination process should address clinical evidence supporting the coverage of interventions for people with disabilities and/or chronic conditions and should specify how the MCO will incorporate appropriate medical or surgical subspecialty or expert opinion or testimony regarding coverage of interventions.

B.1. Definition of Medical Necessity Review Goal: Review should determine if the MCO has defined medical necessity, and how reviewers will use that definition to evaluate coverage decisions.

B.1. Definition of Medical Necessity	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO defines “medical necessity” as a service or treatment that is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain		*				
2. MCO describes how reviewers evaluate coverage decisions against the California contract definition	*					
Reviewer Comments:						

B.2. Utilization Review Guidelines Review Goal: Review should determine how the MCO's utilization review guidelines incorporate clinic evidence, expert opinion, and professional standards.

B.2. Utilization Review Guidelines	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. Written description of the coverage determination process addresses clinical evidence supporting the coverage of interventions for people with disabilities and/or chronic conditions		*				
2. Description of the coverage determination process specifies how the MCO incorporates appropriate medical or surgical subspecialty or expert opinion or testimony regarding coverage of interventions	*	*				
3. When reviewing coverage policies or requests for new technology and investigational treatments, the MCO ensures that:				_____	_____	_____
a. Effectiveness is determined on the basis of scientific evidence	*	*				
b. If insufficient scientific evidence for people with disabilities/ chronic conditions is available, professional standards are considered	*	*				
c. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions are made on the basis of consensus expert opinion	*	*				
d. Coverage of existing interventions is not automatically denied due to the absence of conclusive evidence	*	*				
Reviewer Comments:						

B.2. Utilization Review Guidelines	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	

Additional Reviewer Questions:
Please describe the process for approving new technologies (e.g., annual review board meeting)?

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	C. Qualifications of Reviewers
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Job descriptions and resumes of utilization management program staff	

Background

The Medi-Cal contract language for reviewing treatment requests requires “qualified health professionals” to supervise review decisions, and “qualified physicians” to review all denials.

If there is an appeal involving clinical issues (for example, an appeal of a denied request for coverage), “a health care professional with appropriate clinical expertise in treating the member’s condition or disease” is required. As enrollment of people with disabilities and chronic conditions increases, there will be more requests for coverage of complex, rare, or unusual services (that are not among those typically evaluated by MCO utilization review staff). Involving more specialists in the initial review/denial process will help the plans more quickly evaluate whether specific services should be approved and help members avoid the extra steps involved in appealing a denied service.

The composition of the UM committee is also a critical component of the UM Program. Including providers with experience providing care for people with disabilities or those with chronic illness on the UM committee is key. Most specialty providers in active practice work with people with chronic illness.

C.1. Reviewer Qualifications Review Goal: Review should determine whether the MCO uses qualified staff and physicians to review coverage requests, denials, and appeals.

C.1. Reviewer qualifications	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO describes the qualifications of staff who review utilization decisions		*				
2. MCO uses a qualified physician with appropriate clinical expertise with the members’ condition(s), disability(ies), or disease(s) to review all denials	*					
3. MCO has available practicing physicians with expertise with the member’s condition or disease on a panel to review appeals	*					
Reviewer Comments:						

C.2. UM Committee Review Goal: Review should determine if the MCO's utilization management committee obtains and uses input from providers with experience in treating people with disabilities.

C.2. UM Committee	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO demonstrates effort to include a provider with specific experience/expertise treating people with disabilities/chronic conditions on the UM or QI committees, to provide perspective on disability culture, and the rights and needs of people with disabilities/chronic conditions or MCO demonstrates effort to solicit participation and demonstrates alternative mechanisms for obtaining input of providers with experience and expertise treating people with disabilities/chronic conditions	*					
2. MCO utilization management committee obtains input from practicing physicians who care for people with disabilities and/or chronic conditions as appropriate	*					
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)
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Topic:	D. Authorization of Out-of-Plan Services
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies on out-of-plan service authorization and availability, copies of denial letters and other utilization management communications to members and providers	

Background

Access to out-of-network specialists is a vital component of care for people with disabilities and/or chronic conditions. This is particularly important for people with multiple conditions, who often rely on subspecialists who may or may not participate in MCO networks or delegated medical groups. The MCO shall have policies in place to guide staff in authorizing out-of-plan services when needed services are not available through the plan's network.

D.1. Policies and Procedures Review Goal: Review should determine whether the MCO has policies in place that allow for approval and provision of out-of-plan specialty services when medically necessary.

D.1. Policies and Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has a process for authorizing out-of-plan services		*				
2. The MCO arranges for the provision of specialty services from specialists outside the network if unavailable within the MCO's network, when determined medically necessary		*				
3. MCO has procedures for access to sub-specialists for people with disabilities/chronic conditions outside of the network, when such a sub-specialist is not available in the network		*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)
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Topic:	E. Member Appeals/Provider Appeals
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Appeals policies and procedures, including notification, timelines, and communicating with members with disabilities, member handbook, Web site, provider manual	

Background

There are many mechanisms available for Medi-Cal managed care enrollees to appeal denials of health care services (e.g., internal plan review, Medi-Cal fair hearing, independent medical review). It can be confusing for members to understand the options, and many people do not seem to understand that use of some options precludes appeals through other options. Providers often appeal on behalf of their patients, particularly for people with disabilities and chronic illness (who may need extra assistance because they do not feel well).

To the extent that health plans make it easier for providers to understand how to request services and how to appeal denials, it may be easier for plans to secure the participation of more providers who may be reluctant to participate in Medi-Cal or managed care. Currently, the administrative challenges associated with getting approvals for care creates a disincentive for some providers to accept complex patients into their practice.

E.1. Member Appeal Procedures Review Goal: Review should determine whether the MCO has an appeals system in place that provides timely notification and interpretive services or alternative format materials to members who need them.

E.1. Member Appeal Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a description of the internal review system for the handling, monitoring, and resolution, of member complaints, grievances, and appeals	*	*				
2. MCO describes how notification is made within the timeframes specified in the contract	*	*				
3. MCO informs members and providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations, in the member handbook	*	*				
4. MCO informs members and providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations, on its Web site	*	*				

E.1. Member Appeal Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
5. MCO informs members and providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations, upon request	*	*				
Reviewer Comments:						

E.2. Provider Appeal Procedures Review Goal: Review should determine whether the MCO has an appeals system in place for providers.

E.2. Provider Appeal Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a description of the internal review system for the handling, monitoring, and resolution, of provider complaints, grievances, and appeals	*	*				
2. MCO describes how notification is made within the timeframes specified in the contract	*	*				
3. MCO informs providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations in the provider manual	*	*				
4. MCO informs providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations on its Web site/ provider portal	*					
5. MCO informs providers of patients' appeals rights, including the various mechanisms for filing appeals and their limitations upon request	*					
Reviewer Comments:						

Additional Information

- 1. Are people with disabilities involved in the development of materials related to members understanding their rights and the appropriate appeals procedures? (e.g., focus groups to react to draft member materials)**

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	F. Delegation
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: MCO subcontracts, delegation oversight policies and procedures	

Background

Many health plans delegate large portions of the medical services delivery and utilization management to capitated medical groups. MCOs that delegate functions must submit policies and procedures showing that delegated activities will be regularly evaluated for compliance with contract requirements, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported. This section is only applicable if the MCO delegates quality improvement functions.

F.1. Delegation Requirements Review Goal: Review should determine whether the MCO has adequate delegation oversight in place, as outlined in its subcontract.

F.1. Delegation Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO demonstrates that it is accountable for all quality improvement functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to other entities	*	*				
2. If the MCO delegates quality improvement functions, MCO and delegated entity (subMCO) include in the subcontract, at minimum:				---	---	---
a. Quality improvement responsibilities, and specific delegated functions and activities of the MCO and subMCO						
b. MCO's oversight, monitoring, and evaluation processes and subMCO's agreement to such processes						
c. MCO's reporting requirements and approval processes, including subMCO's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly						

F.1. Delegation Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
d. Actions/remedies if subMCO's obligations are not met						
Reviewer Comments:						

Additional Reviewer Questions:

1. How does the health plan monitor the subMCO and which staff member is responsible?

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)

Care Management Review Tool

The attached questionnaire is designed to assist an evaluator in assessing the MCO's capacity to manage care provided for people with disabilities and chronic conditions. The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation.

The questions are grouped into seven categories:

- A. General Care Management Requirements** contains high-level requirements for the MCO (detailed questions are included in the accompanying review sheets).
- B. Identification and Assessment of People for Care Management** evaluates how members are screened, identified, and referred to care management and how care managers coordinate with providers on an ongoing basis.
- C. Care Manager Qualifications** reviews the MCO's qualifications for clinical and non-clinical staff who participate in care management, as well as staff training requirements.
- D. Care Plan Components** describes the components of the care plan and how it is developed, monitored, stored, and periodically updated.
- E. Disease Management** reviews information on the MCO's disease management program and the role of the disease manager.
- F. Coordination of Out-of-Plan Services** assesses the MCO's approach to ensuring that members are aware of and can access out-of-plan services.
- G. Hospitals and Discharge Planning** describes how the MCO collaborates and coordinates with hospital staff during the discharge planning process.

Items to Review

The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation. Written documents will be examined to ensure that they are compliant with the policies set forth by the Medicaid program. Written documents to be reviewed include the MCO contract and, at a minimum:

- Policies for identification and stratification of members for care management
- Policies on completing and maintaining assessments, including protocols and tools
- Sample care plan (de-identified)
- Job descriptions and resumes of care managers and disease managers
- Disability cultural competency training curriculum and schedule
- Policies on disease management program implementation and goals
- Policies on coordination with out-of-plan services, including directories of services available in the community and procedure for making referrals
- Policies on coordinating with hospitals when a member is admitted and discharged

Reviewers should supplement the policy and procedure review with interviews (in person or by telephone) with MCO staff. These interviews will ensure that qualified staff are aware of and able to implement appropriate written policies and procedures. Staff to interview include, at a minimum:

- Medical Director
- Care management director
- Disease management coordinator
- Care manager supervisor
- Utilization management supervisor (to address linkages between care management and disease management)

Topic:	A. General Care Management Requirements
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Care management program description, policies for identification of members for care management	

Background

Case management and care coordination activities are essential for people with disabilities and chronic conditions who are enrolled in Medi-Cal managed care plans. Case management and care coordination are related activities. Case management typically refers to the coordination of medical services provided by a health plan, often after an acute or catastrophic episode, while care coordination generally means coordination of health and other services (e.g., social services) provided both within and outside of the health plan's scope of covered services. Both case management and care coordination can use multidisciplinary team approaches and both place the member at the center of care so that all medical, social, and personal needs are considered.

Because people with disabilities and chronic conditions may often need assistance from the MCO in coordinating and managing care provided by the health plan as well as carve-out services and support services provided outside of the health plan, the concepts are combined into a single domain that represents a continuum of coordination activities.

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.

A.1. General Care Management Requirements Review Goal: Review should determine whether the MCO has a care management plan in place that outlines identification of members, staff qualifications and training, program monitoring, collaboration, information sharing, and consumer satisfaction.

A.1. General Care Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides care management for members who are identified through the care management assessment mechanisms as needing greater care management than can be provided by the PCP	*					
2. MCO has a written description of the activities and responsibilities that are part of the care management process		*				
3. MCO has procedures to monitor coordination of care among PCP, specialist(s), and other providers		*				

A.1. General Care Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
4. MCO conducts an annual review and evaluation of the care management program description and processes		*				
5. MCO's governing body approves the revised care management program description at least annually		*				
6. MCO seeks input from members, families/ caregivers, and providers and considers this input when updating the care management program description	*					
7. MCO has a standardized procedure/description/ methodology for identifying members for care management, including a process for self-referral	*					<i>Note: More detailed questions included in Section B, Identification and Assessment of People for Care Management</i>
8. MCO has a written description of the qualifications of people who act as care managers		*				
9. MCO has an approach for monitoring care manager caseloads and having sufficient staff available for these functions	*					
10. MCO has a written description of the appropriate methods for using a multi-disciplinary team		*				
11. MCO has a written description of the components of a care plan, including how it is developed and reviewed		*				<i>Note: More detailed questions included in Section D, Care Plan Components</i>
12. MCO has a process for collaborating with carve-out programs		*				
13. MCO has a process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group		*				

A.1. General Care Management Requirements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
14. MCO has a contact person who is responsible for activities delegated to a subcontractor or delegated medical group	*					
15. MCO has a contingency plan in the event that a subcontractor cannot fulfill its contract		*				
16. MCO has a process for obtaining member input on satisfaction with individual care manager services	*					
17. MCO has a consumer satisfaction survey process (phone or mail) for members and uses results to improve care manager services	*					
18. MCO reviews complaints to improve care management services	*					
19. MCO has information systems to support monitoring/management of care plans, the care management program, communication, and information-sharing among care managers and providers		*				
20. MCO has a process to ensure confidentiality of member data		*				
21. MCO has a process to regularly update care plans based on changes in the member's medical or social status		*				
22. MCO has a process to obtain information on recommendations made by nurses staffing after-hours advice lines		*				
23. MCO has a staff training process to ensure that all staff are educated about serving members who have disabilities/chronic conditions		*				

Reviewer Comments:

Additional Reviewer Questions:

1. How does the MCO incorporate input from members, families/ caregivers, and providers when updating the care management program description?

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	B. Identification and Assessment of People for Care Management (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies for identification of members for care management, policies on completing and maintaining assessments, including protocols and tools, sample welcome letter, member handbook	

Background

While all managed care enrollees select (or are assigned) a primary care provider who is responsible for coordinating their care, only a subset of enrollees require additional care management assistance through the MCO. Some of these members may require care management on an ongoing basis due to a chronic or complex condition, while others may require only periodic or one-time assistance with a catastrophic condition or temporary situation.

California requires all new members to receive an Initial Health Assessment (IHA) from their primary care providers during their first visit, which provides the PCP with information to determine what type of care coordination (if any) the member may require. MCOs also conduct an initial screening to assess the needs of new members and refer them to care management if needed.

B.1. Access to Information Review Goal: Review should determine how the MCO gathers and uses available information in its care management efforts.

B.1. Access to Information	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a mechanism to use information provided by DHCS to assess members' need for care management	*					
Reviewer Comments:						

B.2. Member Screening Procedures Review Goal: Review should determine if the MCO has established member screening procedures and a screening tool that identifies special member needs.

B.2. Member Screening Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. Member screening is conducted within 30 days of enrollment, unless screening was conducted by enrollment broker		*				

B.2. Member Screening Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
a. MCO screenings can be completed by phone, mail, in person or a combination Please indicate which methods apply: _____ _____ _____ _____		*				
b. Screening tool identifies members with complex or serious medical conditions		*				
c. Screening tool identifies essential health care needs that may require an expedited appointment with an appropriate provider		*				
d. Screening tool identifies any access or accommodation needs, language barriers, or other factors indicating a need for additional assistance from the health plan		*				
e. Screening tool identifies any caregivers or other decision makers involved in the member's care		*				
f. MCO's contact procedure for screening includes at least three attempts (either at different days/ times or through different mechanisms such as mail, telephone, in-person visit) within 90 days		*				
g. If the MCO cannot contact member or if member refuses to participate in a health screen, the MCO documents that the screen was not completed and encourages the member to schedule an appointment with his or her PCP		*				
Reviewer Comments:						

B.3. New Member Screening Review Goal: Review should determine whether the MCO uses qualified staff to screen new members, whether member information is stored and shared appropriately, and how the MCO screens members on a regular basis.

B.3. New Member Screening	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. New member screening is conducted by qualified people. The following types of staff are used (please indicate all that apply):	*					<i>Follow-up required if MCO does not answer yes to at least one type of staff</i>
a. Nurses (RNs)	*					
b. Social workers	*					
c. Non-clinical staff	*					
d. Other staff (please list): _____ _____ _____ _____	*					
2. Screening data is accessed by qualified staff. The following types of staff can access screening data (please indicate all that apply):	*					<i>Follow-up required if MCO does not answer yes to at least one type of staff</i>
a. Nurses (RNs)	*					
b. Social workers	*					
c. Non-clinical staff	*					
d. Other staff (please list): _____ _____ _____ _____	*					
3. Information is stored on paper or stored electronically. Please indicate:_____	*					
4. Screening information is updated by qualified staff. The types of staff that can update screening data include (please indicate all that apply):	*					<i>Follow-up required if MCO does not answer yes to at least one type of staff</i>
a. Nurses (RNs)	*					
b. Social workers	*					
c. Non-clinical staff	*					

B.3. New Member Screening	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
d. Other staff (please list): _____ _____ _____	*					
5. Members are screened at enrollment, annually or at another interval. Please indicate: _____	*					
Reviewer Comments:						

B.4. MCO Screening Components Review Goal: Review should determine if the MCO's screening process addresses aspects of member health history, provider relationships, services received, and other member-specific issues.

B.4. MCO Screening Components	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO screening includes the following (please indicate all that apply):		*		_____	_____	<i>Follow-up required if MCO does not answer yes to all items</i>
a. Health history		*				
b. Current PCP		*				
c. Current in-network specialists		*				
d. Current non-network specialists		*				
e. Current/planned treatment		*				
f. Psychosocial factors		*				
g. Use of non-covered services		*				
h. Family/caregiver support		*				
i. Guardianship issues		*				
j. External case managers		*				
k. Comprehension barriers		*				
l. Physical limitations/barriers		*				
m. Please list other screening components: _____ _____ _____ _____		*				

B.4. MCO Screening Components	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
Reviewer Comments:						

B.5. Triggers for Identifying Members as High Risk Review Goal: Review should determine whether the MCO uses established conditions to identify a high-risk member.

B.5. Triggers for Identifying Members as High Risk	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO uses the following triggers to identify members as being high risk (please indicate all that apply):		*		_____	_____	_____
a. Chronic homelessness/living arrangements		*				
b. Receipt of in-home supportive services		*				
c. Safety concerns		*				
d. Presence of a caregiver		*				
e. Enrollment in a county behavioral health program		*				
f. Enrollment in or contact with a community-based long-term care system		*				
g. Regular visits to multiple specialists		*				
h. Presence of cognitive impairment or certain conditions (Please list conditions) _____ _____ _____		*				
i. Missed appointment		*				
j. Referrals		*				
k. Multiple conditions that could qualify for disease management		*				
l. Participation in multiple disease management programs		*				

B.5. Triggers for Identifying Members as High Risk	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
m. Other triggers (please list): _____ _____ _____ _____		*				
Reviewer Comments:						

B.6. Referrals to Care Management Review Goal: Review should determine if the MCO refers members to case management as needed and appropriate, and has mechanisms to identify the need for member referrals.

B.6. Referrals to Care Management	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. Members are referred to care management under one or more of the following circumstances (please indicate all that apply):		*		_____	_____	_____
a. Member request (required)		*				
b. Family member request (required)		*				
c. Guardian/caregiver request (required)		*				
d. Referral from PCP (required)		*				
e. Referral from specialist (required)		*				
f. Referral from other provider (list) _____ _____ _____ _____		*				
g. Referral from MCO staff		*				
h. Presence of an external care manager		*				
i. Review of utilization and claims/ encounter data, emergency room visits, lab, pharmacy scripts, DME, transplant request, and hospitalizations		*				
j. Routine mining of claims/ encounter data with algorithms established by the MCO		*				

B.6. Referrals to Care Management	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
k. Routine examination of specific DRG or CPT codes (specify): _____ _____ _____ _____		*				
l. Routine examination of large claims or dollar volume		*				
m. Routine examination of certain diagnoses (specify): _____ _____ _____ _____		*				
n. Triggers identified as being risk factors during initial screening of new members or during a later assessment		*				
o. Participation in multiple disease management programs		*				
p. Identification of multiple conditions that could qualify for disease management		*				
q. Auto-assignment (of people in certain aid codes) to a PCP, which may indicate a concern with continuity of care		*				
r. Please list other circumstances that would merit referral to the MCO's case management program: _____ _____ _____ _____		*				
Reviewer Comments:						

B.7. Member Education about Care Management Review Goal: Review should determine if the MCO has established methods for educating members about the availability of care management services.

B.7. Member Education about Care Management	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO educates members about available care management services. MCO uses the following mechanisms to educate members about their ability to request care management (please indicate all that apply):	*					
a. Welcome letter	*					
b. Welcome call	*					
c. Member handbook	*					
d. Outreach visit	*					
e. Please list other ways members are educated about the MCO's care management program: _____ _____ _____ _____	*					
Reviewer Comments:						

B.8. Care Management Procedures Review Goal: Review should determine whether the MCO has established care management procedures that include processes for care coordination, interaction with providers, timeframes for review, and guidelines on the care management approach.

B.8. Care Management Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO ensures that the care manager coordinates with the member, PCP, other providers, and other care managers	*					
2. MCO has a process for notifying PCP of care manager assignment if he/she requested assignment	*					
3. MCO has guidelines for care manager contact with PCPs (e.g., frequency, method)	*	*				

B.8. Care Management Procedures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
4. MCO has guidelines for care manager contact with external care managers (e.g., frequency, method)	*	*				
5. MCO has timeframes for reviews to ensure that care managers serve members consistently	*	*				
6. Note frequency of care manager reviews: _____		*		_____	_____	
7. Care managers use a telephonic approach	*					
8. Care managers make home visits	*					
9. Care managers can contact practicing physicians with questions regarding care planning	*					
10. After a request is made, average days for a member to be assigned a care manager: _____	*			_____	_____	
Reviewer Comments:						

Additional Reviewer Questions:

- 1. How does the MCO ensure the confidentiality of member information in a shared health record? (e.g., limited access to information, passwords)**

- 2. Under what circumstances would the care manager interact with PCPs, specialists or other providers?**

- 3. Under what circumstances would the care manager interact with external care managers?**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	C. Care Manager Qualifications (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Job description and resumes for care managers, disability cultural competency training curriculum and schedule	

Background

The MCO shall use qualified care managers, including licensed (or certified) registered nurses, social workers, rehabilitation counselors/therapists, physician 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.

The MCO shall conduct disability cultural competency training for all staff, covering topics as delineated in this readiness review guide.

C.1. Care Managers Review Goal: Review should determine whether the MCO has established care manager responsibilities and training methods, and is able to manage care manager workload appropriately.

C.1. Care Managers	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a written job description for care managers		*				
2. MCO has pre-determined ratios for care manager caseloads or another mechanism for monitoring workload		*				
3. MCO has a process for temporarily assisting care managers whose caseload becomes burdensome	*	*				
4. MCO has a process for adding care managers as enrollment increases	*	*				
5. MCO has a process for training care managers on an ongoing basis	*	*				
Reviewer Comments:						

C.2. MCO's Clinical Staff Qualification Requirements Review Goal: Review should determine what the MCO considers to be appropriate clinical staff qualifications, such as degrees, specialized training, certifications, or previous experience.

C.2. MCO's Clinical Staff Qualification Requirements	Int	Doc	Reviewer Source	Req.	Pref.	Comments/questions for follow-up
1. Please note required and preferred staff qualifications for clinical staff in the columns to the right:		*		_____	_____	_____
a. Degrees		*				
b. Special training or certifications		*				
c. Years of clinical experience		*				
d. Years of care management experience		*				
e. Experience with Medicaid		*				
f. Experience with special needs populations		*				
Reviewer Comments:						

C.3. MCO's Non-Clinical Staff Qualification Requirements Review Goal: Review should determine what the MCO considers to be appropriate qualifications for non-clinical staff, such as degrees, specialized training, certifications, and previous experience.

C.3. MCO's Non-Clinical Staff Qualification Requirements	Int	Doc	Reviewer Source	Req.	Pref.	Comments/questions for follow-up
1. Please note required and preferred staff qualifications for non-clinical staff:		*		_____	_____	_____
a. Degrees		*				
b. Special training or certifications		*				
c. Years of clinical experience		*				
d. Years of care management experience		*				
e. Experience with Medicaid		*				
f. Experience with special needs populations		*				
Reviewer Comments:						

C.5. MCO's Training Requirements Related to Disability Cultural Competency Review Goal: Review should determine if the MCO trains its staff on disability cultural competency, including on issues related to member needs, benefits, ADA compliance, barriers, and prevalent conditions.

C.5. MCO's Training Requirements Related to Disability Cultural Competency	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO conducts periodic staff training for disability cultural competency. Frequency: _____	*					
2. MCO uses skilled staff to facilitate training. Trainer qualifications: _____ _____ _____ _____	*	*				
3. Training includes various types of chronic conditions and disabilities prevalent among Medi-Cal beneficiaries		*				
4. Training includes awareness of personal prejudice		*				
5. Training includes legal obligations to comply with the Americans with Disabilities Act (ADA)		*				
6. Training includes 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 PCPs		*				
7. Training includes definitions and concepts such as communication access, medical equipment access, physical access, and access to programs		*				
8. Training includes types of barriers that adults with physical, sensory, communication disabilities, developmental or mental health needs face in health care and the resulting access and accommodation needs		*				

C.5. MCO's Training Requirements Related to Disability Cultural Competency	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
9. Training includes behavioral health issues among people with disabilities of all ages		*				
Reviewer Comments:						

C.6. Assignment of Care Managers to Members Review Goal: Review should determine how the MCO assigns care managers to members appropriately.

C.6. Assignment of Care Managers to Members	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides care management to some or all of its members (please indicate all that apply):		*				
a. All members are assigned a case manager		*				
b. Some members are assigned a care manager. Specify population(s): _____ _____ _____ _____		*				
c. Care managers are randomly assigned	*	*				
d. Care managers are assigned based on disease	*	*				
e. Care managers are assigned based on care manager's workload	*	*				
f. Care managers are assigned based on geography	*	*				
g. Care managers are assigned based on care manager's language skills	*	*				
h. Care managers are assigned based on MCO-assigned risk level for the member	*	*				

C.6. Assignment of Care Managers to Members	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
i. Specify care manager to member ratio: _____		*		—	—	
Reviewer Comments:						

Additional Reviewer Questions:

1. Does the MCO require care managers to have expertise specific to people with special needs? (e.g., HIV/AIDS, mental health, sensory impairments)

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	D. Care Plan Components (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: De-identified sample care plan, care management program description	

Background

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).

The intent of the care plan is to provide a systematic, comprehensive care strategy that is routinely communicated to individuals participating in the member's care. Medi-Cal MCOs usually develop a care plan shortly after the identification and assessment of a member needing care management. The care plan is initiated by the care manager. Many elements go into the care plan itself and involve multiple facets of care.

D.1. Care Plan Components Review Goal: Review should determine if the MCO care plans contain information about the member's needs, barriers, and available resources.

D.1. Care Plan Components	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. Reviewer should look at an actual care plan to determine whether it contains the following components (please indicate all that apply):		*		_____	_____	
a. Health status and risk for secondary disabilities or complications		*				
b. Clinical history		*				
c. Age		*				
d. Diagnosis(es)		*				
e. Functional and/or cognitive status		*				
f. Mental health		*				
g. Language/comprehension barriers		*				
h. Cultural/linguistic needs, preference, or limitations		*				
i. Level of intensity of care management		*				
j. Immediate service needs		*				
k. Use of non-covered services		*				

D.1. Care Plan Components	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
l. Barriers to care		*				
m. Follow-up schedule		*				
n. Network or out-of-network care		*				
o. Family members/ caregiver/ facilitator resources and contact information (if appropriate)		*				
p. Local community resources		*				
q. Psychosocial support resources		*				
r. Accessible medical equipment		*				
s. Assessment of progress, including input from family, if appropriate		*				
t. Accommodation needs (e.g., appointment time or alternative formats such as Braille, large print, disks, audio, electronic) and auxiliary aids and services		*				
Reviewer Comments:						

D.2. Participation in Care Plan Development Review Goal: Review should determine if the MCO uses all appropriate input when developing care plans, and if care plans are shared with members and their providers.

D.2. Participation in Care Plan Development	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO includes the following when developing a care plan (please indicate all that apply):	*	*				
a. MCO reviews medical records		*				
b. MCO seeks input from member		*				
c. MCO seeks input from PCP		*				
d. MCO seeks input from specialists		*				
e. MCO seeks input from other providers (please specify): _____ _____ _____ _____	*	*				

D.2. Participation in Care Plan Development	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
f. PCP must sign care plan	*	*				
g. Member receives copy of care plan		*				
h. PCP receives copy of care plan		*				
Reviewer Comments:						

D.3. Care Plan Monitoring Review Goal: Review should determine whether the MCO makes information in the care plan available to members and providers, and whether the care plan is monitored and updated in an appropriate timeframe.

D.3. Care Plan Monitoring	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. A member's care manager has access to the care plan	*	*				
2. Other members of the care management team have access to the care plan. Specify: _____	*	*				
3. Care plan is routinely monitored to ensure continuity of care		*				
4. Information in the care plan is available to the member upon request		*				
5. Information in the care plan is available to the PCP upon request		*				
6. MCO periodically evaluates care plan to ensure it continues to meet member's needs. Frequency: _____		*				
7. MCO has criteria for discharge and transitioning members from care management		*				
8. MCO has triggers for re-assessing member needs		*				
9. MCO ensures reassessment occurs if member is hospitalized		*				
10. MCO ensures reassessment occurs if member enters a nursing facility		*				

D.3. Care Plan Monitoring	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
11. MCO ensures reassessment occurs if member has a change in caregiver support		*				
Reviewer Comments:						

D.4. Other Review Items Review Goal: Review should determine if appropriate MCO staff have access to the care plan, and if the MCO uses appropriate staff to update care plans.

D.4. Other Review Items	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a timeframe for developing individualized care plans (from start to finish). Please specify: _____ days		*				
2. Non-clinical staff have access to the care plan		*				
3. Other MCO staff have access to the care plan		*				
4. Care plan is updated periodically Frequency: _____		*				
5. Care plan is updated by the care manager		*				
6. Care plan is updated by other MCO staff. Specify: _____		*				
7. Care plan is tracked electronically		*				
8. MCO's systems has triggers that notify the care manager if a specific intervention is needed		*				
Reviewer Comments:						

Additional Reviewer Questions:

- 1. Please describe the process for creating a rational care plan for each member, including how is it developed, who is involved in the development and what it contains.**

- 2. Who is required to sign the care plan? (e.g. PCP, case manager, member)**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	E. Disease Management (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies on disease management program implementation and goals, disease manager job description	

Background

Disease management (DM) is "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." MCOs are responsible for initiating and maintaining a disease management program. The MCO determines the program's targeted disease conditions and implements a system to identify and encourage members to participate, which may include using member incentives to encourage use of recommended services or behaviors.

E.1. Disease Management (DM) Program Review Goal: Review should determine whether the MCO has an established DM program that outlines the diseases addressed, identification and stratification of members, coordination of care, communication with the member, and caring for members with multiple conditions.

E.1. Disease Management (DM) Program	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has policies and procedures that address its DM program. The following aspects of the program are included:		*				
a. MCO identifies diseases and conditions to be addressed by the MCO's DM program through several methods (e.g., claims analysis)		*				
b. MCO identifies and stratifies members who may be appropriate for enrollment in disease/ multiple chronic conditions management		*				
c. DM staff coordinate with the PCP/medical home		*				
d. DM staff coordinate/link with care management		*				
e. DM staff communicate with the member		*				
f. MCO has strategies for providing DM for members with multiple chronic illnesses or conditions		*				
Reviewer Comments:						

E.2. Disease Management (DM) Program Elements Review Goal: Review should determine if the MCO's DM program includes elements such as education, evidence-based care, interventions, and monitoring.

E.2. Disease Management (DM) Program Elements	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. DM program includes self-management education		*				
2. DM program includes provider education		*				
3. DM program includes evidence-based standards of care (to the extent that these are available)		*				
4. DM program includes physician-directed or physician-supervised care		*				
5. DM program includes implementation of interventions that address continuum of care		*				
6. DM program includes mechanisms that modify or change interventions that are not proven to be effective		*				
7. DM program includes mechanisms to monitor the clinical impact of the program over time		*				
8. DM program includes mechanisms to monitor the financial impact of the program over time		*				
9. MCO allows member to opt out of DM within 30 days of enrollment		*				
Reviewer Comments:						

E.3. Disease Manager Role Review Goal: Review should determine how MCO disease managers communicate with members and providers, and whether the MCO monitors disease manager consistency.

E.3. Disease Manager Role	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO ensures that the disease manager coordinates with the PCP		*				
2. MCO ensures that disease manager notifies the member's PCP that he/she participates in the DM program		*				
3. MCO ensures that the disease manager coordinates with the care manager		*				
4. Disease manager communicates with the member by phone		*				
5. Disease manager communicates with the member by mail		*				
6. Disease manager communicates with the member electronically		*				
7. MCO conducts reviews to ensure that disease managers serve members consistently		*				
8. Frequency of reviews: _____		*				
Reviewer Comments:						

Additional Reviewer Questions:

- How are members selected and enrolled in the disease management program? (e.g., claims data analysis)**

- Please describe the disease management intervention? Are there different interventions for people with different disease severity? (e.g., educational materials, phone calls)**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	F. Coordination of Out-of-Plan Services (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies on coordination with out-of-plan services, including directories of services available in the community and procedure for making referrals; member handbook, sample welcome letter or welcome call script, Web site, member newsletters, provider training materials, provider manual, provider newsletter	

Background

In the Medi-Cal system, many services (e.g., specialty mental health, alcohol and substance abuse treatment, dental, California Children’s Services, long-term care, home- and community-based waiver services, and chiropractic) needed by members with disabilities are carved out of the MCO’s responsibility and are provided instead by specialty providers who are reimbursed through fee-for-service Medi-Cal. MCOs are required to implement procedures to identify individuals who may need or are receiving services from out-of-plan providers and/or programs to ensure coordinated service delivery.

F.1. Programs With Which to Coordinate Review Goal: Review should determine whether the MCO has an established plan to coordinate with outside programs, and if the plan maintains a comprehensive list of these programs.

F.1. Programs with which to Coordinate	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO has a plan to coordinate with out-of-plan programs. The following programs are included in its plan (please indicate all that apply):	*	*				
a. State/federal aging agencies	*	*				
b. State/federal public health departments/ agencies	*	*				
c. State/federal substance abuse agencies	*	*				
d. State/federal mental health/retardation, rehabilitation agencies	*	*				
e. State/federal developmental disabilities agencies	*	*				
f. State/federal income support agencies	*	*				
g. State/federal nutritional assistance agencies (e.g., WIC)	*	*				
h. State/federal family support agencies	*	*				
i. Intensive case management program	*	*				
j. Early Intervention Program (EIP)	*	*				

F.1. Programs with which to Coordinate	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
k. Individual Education Plan (IDEA) school-based coordinator	*	*				
l. Long-term care case managers for people with developmental disabilities	*	*				
m. Targeted Case Management services	*	*				
n. Out-of-plan case managers	*	*				
o. HIV/AIDS Ryan White providers	*	*				
p. Local education agency (LEA) services	*	*				
q. Area Agencies on Aging	*	*				
r. Residential support agencies	*	*				
s. Independent living centers	*	*				
t. Supported employment agencies	*	*				
u. City and county welfare departments	*	*				
v. City and county housing programs	*	*				
w. Civic organizations	*	*				
x. Religious organizations	*	*				
y. Legal aid offices	*	*				
z. Consumer/family support groups	*	*				
aa. California Children Services (CCS)	*	*				
Reviewer Comments:						

F.2. Agreements with Community Programs Review Goal: Review should determine how the MCO will develop formal and informal agreements and relationships with community organizations, and how these agreements will be maintained.

F.2. Agreements with Community Programs	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO provides evidence that it develops formal agreements with community based organizations (e.g., Memoranda of Understanding)		*				

F.2. Agreements with Community Programs	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
2. MCO provides evidence that it develops informal relationships with community based organizations		*				
3. Staff person (and title) responsible for maintaining agreements: _____		*		_____	_____	
4. Frequency that agreements are updated/renewed: _____		*		_____	_____	
Reviewer Comments:						

F.3. Maintenance of Community Resource List Review Goal: Review should determine whether the MCO maintains a list of community resources that is available to staff, and how the list is maintained and updated.

F.3. Maintenance of Community Resource List	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO maintains a list of community resources to refer its members		*				
2. Staff person(s) (and title(s)) responsible for maintaining the community resource list: _____ _____ _____		*				
3. The list is updated periodically Frequency: _____		*				
4. The list is available to MCO staff who interact with members		*				
Reviewer Comments:						

F.4. Education of Members about Non-Covered Services Review Goal: Review should determine how the MCO educates members about non-covered services.

F.4. Education of Members about Non-Covered Services	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO uses the following mechanisms to educate members about non-covered services (please indicate all that apply):		*		_____	_____	_____
a. Member handbook		*				
b. Welcome letter or welcome call		*				
c. Information session		*				
d. Home visit		*				
e. Orientation		*				
f. Web site		*				
g. Member hotline		*				
Reviewer Comments:						

F.5. Education of Members about Non-Covered Services on an Ongoing Basis Review Goal: Review should determine how the MCO educates members on changes to the availability of non-covered services.

F.5. Education of Members about Non-Covered Services on an Ongoing Basis	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO uses the following mechanisms to educate members about changes to the availability of non-covered services (please indicate all that apply):		*		_____	_____	_____
a. Member handbook updates		*				
b. Member newsletters		*				
c. Outreach		*				
d. PCPs		*				
e. Case managers/ care coordinators		*				
Reviewer Comments:						

F.6. Education of Providers about Non-Covered Services on an Ongoing Basis Review Goal:

Review should determine how the MCO educates providers and provider staff on changes to the availability of non-covered services.

F.6. Education of Providers about Non-Covered Services on an Ongoing Basis	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO uses the following mechanisms to educate providers and their staff about changes to the availability of non-covered services:		*		_____	_____	_____
a. Annual or other periodic training		*				
b. Provider manual		*				
c. Provider newsletter		*				
d. Web site		*				
e. One-on-one visits to provider offices		*				
Reviewer Comments:						

F.7. Education of MCO Staff about Non-Covered Services on an Ongoing Basis Review Goal:

Review should determine how the MCO educates its own staff on changes to the availability of non-covered services.

F.7. Education of MCO Staff about Non-Covered Services on an Ongoing Basis	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO uses the following mechanisms to educate staff about changes to the availability of non-covered services:		*		_____	_____	_____
a. Annual or other periodic training Frequency: _____		*				
b. Internet Web site updates		*				
c. Informational materials		*				
Reviewer Comments:						

F.8. Identification of Member Need for Non-Covered Services Review Goal: Review should determine how the MCO identifies member needs for non-covered services.

F.8. Identification of Member Need for Non-Covered Services	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO staff identify member needs for non-capitated services in the following manners:		*		___	___	___
a. Member outreach and education		*				
b. Part of treatment plan update process		*				
c. Review of medical records		*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	G. Hospitals and Discharge Planning (Care Management)
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Policies on coordinating with hospitals when a member is admitted and discharged	

Background

Members who are hospitalized may face a new array of service needs upon hospital discharge. The MCO should be involved in the discharge planning process starting at the member’s admission to the hospital and the care manager will assist in ensuring that a the member is discharged to a skilled nursing facility for rehabilitation or that a comprehensive set of community supports can be provided.

G.1. Coordination with Hospital Discharge Planners Review Goal: Review should determine how and when the MCO coordinates with hospital discharge planners.

G.1. Coordination with Hospital Discharge Planners	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO coordinates with hospital discharge planners starting upon admission of a member. The following mechanisms are used:		*				
a. In-person at the hospital		*				
b. By phone		*				
Reviewer Comments:						

G.2. Discharge Planning Collaboration Review Goal: Review should determine who the MCO care managers collaborate with during the discharge planning process, and whether the member is made aware of community-based options.

G.2. Discharge Planning Collaboration	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO care manager collaborates with the following individuals during the discharge planning process:		*		_____	_____	_____
a. Member		*				
b. Member’s family		*				
c. Guardian/caregiver, if applicable		*				
d. Hospital discharge planner		*				
e. Member’s PCP		*				
f. Attending physician		*				

G.2. Discharge Planning Collaboration	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
2. MCO ensures that the member and the member's family are aware of community based placement options		*				
Reviewer Comments:						

Additional Reviewer Questions:

1. When does the discharge planning process begin? (e.g., once inpatient stay is authorized)
2. What occurs between admission and discharge to develop a plan for community-based placement? (e.g., MCO staff visit hospital to assist with plan development)
3. What kind of follow-up occurs post-discharge? (e.g., MCO follows up with member after 7 days)
4. How does the MCO ensure that members, family members, and PCPs are informed of all service options within the community that meet members' needs? (e.g., in-person meeting, Web site)

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Quality Improvement and Performance Measurement Review Tool

The attached questionnaire is designed to assist an evaluator in assessing the MCO's ability to promote quality improvement for all services to people with disabilities and chronic conditions. The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation.

The questions are grouped into five categories:

- A. General Quality Management Requirements** contains high-level requirements for the MCO (detailed questions are included in the accompanying review sheets).
- B. Identifying Members with Disabilities and Multiple Chronic Conditions** evaluates specifications related to data analysis to identify members with disabilities and chronic conditions.
- C. Quality Indicators** reviews areas in which quality is measured, including both MCO procedures (e.g., member/ provider ratios) and utilization data analysis.
- D. Quality Improvement Description and Projects** assesses the MCO's required quality improvement projects.
- E. Identifying and Sharing Evidence-Based Guidelines among MCOs and Engaging Providers** determines the collection and dissemination of evidence-based guidelines.

Items to Review

The review will require a mix of document review and interviews with MCO staff to assess the various areas of operation. Written documents will be examined to ensure that they are compliant with the policies set forth by the Medicaid program. Written documents to be reviewed include the MCO contract and, at a minimum:

- Quality improvement system description
- Policies and procedures related to quality assurance and improvement
- Results of recent quality improvement studies (both clinical and non-clinical)
- Sample provider profiles, if any, quality reports, survey findings, etc.
- Sample clinical practice guidelines and clinical decision support tools

Reviewers should supplement the policy and procedure review with interviews (in person or by phone) with MCO staff. These interviews will ensure that qualified staff are aware of and able to implement the written policies and procedures. Staff to interview include, at a minimum:

- Quality Improvement Unit manager
- Quality Improvement nurse manager

Topic:	A. General Quality Improvement
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Quality improvement system description	

Background

Quality Improvement (QI) is a systematic and continuous activity to improve all processes and systems in the organization to achieve an optimal level of performance. QI extends not just to improvements in clinical care (e.g., reducing avoidable hospitalizations), but also to non-clinical areas (e.g., improving member services procedures).

Improving health care quality for people with disabilities and chronic conditions may be more difficult than for a healthy population. In Medi-Cal, beneficiaries with disabilities are five times more likely to have two or more chronic conditions than other Medi-Cal beneficiaries. The more conditions a person has, the more complex his or her health care needs are. Health plans should augment their existing quality improvement processes to effectively meet the needs of people with disabilities and/or chronic conditions.

A.1. General Quality Improvement Activities Review Goal: Review should determine whether the MCO has a quality improvement plan in place that identifies and how the MCO tracks information specific to members with disabilities and chronic conditions.

A. 1 General Quality Improvement Activities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO gathers QI data specific to people with disabilities/chronic conditions		*				
2. MCO uses QI data to identify gaps in care for people with disabilities/chronic conditions		*				
3. MCO has a process to identify and disseminate best practices specific to people with disabilities/chronic conditions (e.g., newsletters)	*	*				
4. MCO has a procedure to track members with disabilities/chronic conditions and analyze data associated with their claims	*	*				

Reviewer Comments:

A.2. Internal Studies to Evaluate Quality of Care Review Goal: Review should determine how the MCO monitors and coordinates care for members with disabilities and chronic conditions.

A. 2 Internal Studies to Evaluate Quality of Care	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO conducts internal studies to evaluate quality of care for people with disabilities/chronic conditions	*	*				
2. MCO monitors primary care delivered to members who have selected specialists as PCPs	*	*				
3. MCO provides coordination of care with other systems of care/external case managers	*	*				
4. MCO monitors care delivered in provider offices to ensure people with disabilities/chronic conditions are treated fairly	*	*				
5. MCO monitors treatment plan compliance	*	*				
6. Please list other ways the MCO ensures quality of care for people with disabilities/chronic conditions _____ _____ _____ _____	*	*				
Reviewer Comments:						

A.3. External Input on Quality Improvement Program Review Goal: Review should assess how the MCO involves stakeholders and providers in overseeing quality improvement activities for members with disabilities and chronic conditions.

A. 3 External Input on Quality Improvement Program	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO involves stakeholders in developing quality monitoring approaches	*	*				
2. MCO involves stakeholders in identifying standards and measures	*	*				
3. MCO involves stakeholders in overseeing quality activities and reviewing findings	*	*				

A. 3 External Input on Quality Improvement Program	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
4. MCO's quality improvement committee includes physicians and psychologists who represent a range of health care services used by members with disabilities/chronic conditions	*	*				
5. MCO seeks input of members' providers related to quality of care	*	*				
Reviewer Comments:						

Additional Reviewer Questions:

- 1. What are the MCO's planned quality assurance activities relating to members with disabilities and/or chronic conditions? (e.g., stratifying data, reviewing claims trends)**

- 2. How is quality assurance linked through all areas of the MCO's work?**

- 3. How does the MCO identify stakeholders to participate in QI activities?**

Additional Information

Overall Reviewer Assessment (explain any "no" items and how the MCO should address these)

Topic:	B. Identifying Members with Disabilities and Multiple Chronic Conditions
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Quality improvement system description, policies and procedures related to quality assurance and improvement	

Background

Quality improvement seeks to upgrade care for members across all health plan services. As a first step, MCOs need to identify the population, service, or clinical issue needing improvement. This can be done by analyzing several sources of data (e.g., annual evaluation, group needs assessment, results from the Consumer Assessment of Healthcare Providers and Systems [CAHPS] health plan survey, performance on the Health Plan Employer Data and Information Set [HEDIS] measures, and member grievances). In addition, MCOs use inpatient, outpatient, pharmacy data, and diagnostic/procedure codes to identify populations that are not receiving appropriate care.

Members with disabilities and multiple chronic conditions must be identified as a subset of the MCO's overall membership for quality improvement activities, because some areas of concern may occur frequently among this population yet be relatively rare across the MCO membership as a whole. Once the subset is identified, the data should be analyzed to find opportunities for clinical or service improvement.

B.1. Using Member Data to Support Quality Improvement Activities Review Goal: Review should determine how the MCO tracks and analyzes data for members with disabilities and chronic conditions and how these data are used to develop quality improvement interventions.

B. 1 Using Member Data to Support QI Activities	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO tracks and analyzes member data to support QI activities		*				
2. MCO stratifies utilization data to capture statistically significant results for members with disabilities/chronic conditions		*				
3. MCO designs and implements QI activities/interventions based on the needs of targeted groups of members with disabilities/ chronic conditions		*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	C. Quality Indicators
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Quality improvement system description, policies and procedures related to quality assurance and improvement	

Background

Medi-Cal plans are required to submit encounter data to DHCS to produce Use of Service Reports. These reports allow for comparisons of utilization rates among MCOs. Utilization data include: outpatient visits, emergency room visits, total hospitalizations, pharmacy costs, and laboratory tests. Collecting these data is essential because they offer rough measures of people's ability to access services. Although no national benchmarks exist for "proper utilization performance," some utilization measures are useful indicators of positive medical outcomes, tracking of utilization over time can suggest potential problem areas or successes. For example, lower emergency room utilization rates from year to year can be an indicator of improving access to primary care.

Durable medical equipment use and hospitalizations for ambulatory sensitive conditions are particularly relevant for people with disabilities and multiple chronic conditions because they tend to have higher utilization in these two areas.

C.1. Quality Indicators/ Measures Used to Monitor the Quality of Care Delivered to SSI Members

Review Goal: Review should determine whether the MCO tracks quality indicators for SSI members.

C. 1 Quality Indicators/Measures Used to Monitor the Quality of Care Delivered to SSI Members	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCOs tracks quality indicators specific to members with disabilities/chronic conditions		*				
2. MCO tracks complaints and grievances from SSI members		*				
3. MCO tracks requests/referrals to non-network providers		*				
4. MCO tracks requests for PCP changes		*				
5. MCO tracks provider ratios for highly-utilized specialties		*				
6. MCO tracks requests for expedited utilization review decisions		*				
7. Please list other MCO efforts to track quality of care for people with disabilities/chronic conditions _____ _____ _____ _____	*	*				

C.2. Utilization Data Areas Review Goal: Review should determine whether the MCO collects utilization data for durable medical equipment and preventable hospitalizations for members with disabilities and chronic conditions.

C. 2 Utilization data areas	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO collects SSI utilization data for durable medical equipment		*				
2. The MCO collects SSI utilization data for preventable hospitalizations		*				
Reviewer Comments:						

C.3. HEDIS Measures Review Goal: Review should determine whether the MCO collects certain HEDIS measures for members with disabilities and chronic conditions.

C. 3 HEDIS Measures	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO calculates the following HEDIS measures for SSI members:		*		—	—	—
a. Comprehensive diabetes exam (retinal eye exam, HBA1c test, LDL screening, and neuropathy screening)		*				
b. Antidepressant medication management		*				
c. Controlling high blood pressure		*				
d. Annual monitoring of patients on persistent medication		*				
e. Cholesterol management for members with acute cardiovascular conditions		*				
f. Beta-blocker treatment after a heart attack		*				
g. Persistence of beta-blocker treatment after a heart attack		*				
Reviewer Comments:						

Additional Reviewer Questions:

- 1. What utilization data/ quality indicators does the health plan currently examine on a routine basis?**

- 2. How does the MCO monitor improvement among providers in meeting quality improvement goals? (e.g., annual provider profiles)**

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	D. Quality Improvement Description and Projects
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Quality improvement system description, quality reports and quality survey findings, sample provider profiles	

Background

Each MCO must implement and maintain a written description of its quality improvement systems, addressing various aspects of its QI processes such as descriptions of the mechanisms for ensuring and monitoring quality of clinical services and the mechanisms used to review access to and availability of care, as well as other methods used to target quality improvements. A subset of the MCO's quality improvement activities should focus on people with disabilities and chronic conditions. MCOs are required to conduct four Quality Improvement Projects (QIPs). One of these must be a statewide collaborative project, which can provide an opportunity to share best practices across MCOs.

As Medi-Cal MCOs enroll more people with disabilities and chronic conditions, it will be important to establish baseline information about their new membership (e.g., access to services and satisfaction with services).

D.1. Quality Improvement System Description Projects Review Goal: Review should determine whether the MCO has an appropriate quality improvement system description in place.

D. 1 Quality Improvement System Description	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO has a written quality improvement system description		*				
2. QI system description describes mechanisms for ensuring and monitoring quality of clinical services		*				
3. QI system description explains mechanisms used to review access to and availability of care		*				
4. QI system description describes methods used to target quality improvements		*				
Reviewer Comments:						

D.2. Quality Improvement Process Review Goal: Review should determine whether the MCO has an appropriate quality improvement process in place.

5. Quality Improvement Process	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO lists objective quality indicators used to evaluate performance		*				
2. MCO solicits member and provider input on performance and QI activities		*				
3. MCO measures clinical and non-clinical effectiveness and member satisfaction on an on-going basis		*				
4. MCO reviews clinical and non-clinical processes and makes improvements, as needed	*					
5. MCO continually develops and implements QI interventions	*					
Reviewer Comments:						

D.3. Quality Improvement Projects Review Goal: Review should determine the nature of the MCO's planned quality improvement projects, ensuring that at least one is specific to the needs of members with disabilities and chronic conditions.

6. Quality Improvement Projects	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. MCO conducts at least four Quality Improvement Projects (QIP) each year		*				
2. MCO conducts at least one QIP on an issue related to people with disabilities and chronic conditions.		*				
Reviewer Comments:						

Additional Reviewer Questions:

1. What does the MCO intend to examine for its four Quality Improvement Projects in the first year? (e.g., In the first year, the MCO will focus on issues such as access and consumer satisfaction; in the second and third years, the MCO will focus on improving clinical outcomes.)

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)

Topic:	E. Identifying and Sharing Evidence-Based Guidelines Among MCOs and Engaging Providers
Contract Section:	<i>To be determined</i>
Suggested Documents to Review: Sample clinical practice guidelines, clinical decision support tools, provider education related to best practices	

Background

While there are many disease-specific guidelines, many studies exclude people with co-morbidities, the elderly, and people with disabilities. As a result, the evidence base for people with complex clinical needs and physical disabilities in many cases does not exist or is only marginally relevant for people with comorbidities. Where few evidence-based guidelines exist, MCOs need to support providers in accessing best practices and other types of clinical decision-support tools.

E.1. Evidence-Based Guidelines Review Goal: Review should determine how the MCO will identify and encourage the use of evidence-based guidelines among participating providers.

E. 1 Evidence-Based Guidelines	Int	Doc	Reviewer Source	Compliant		Comments/questions for follow-up
				Yes	No	
1. The MCO identifies evidence-based guidelines and shares them with other MCOs and with providers		*				
2. MCO provides clinical decision-support tools to its network providers		*				
3. MCO has a process to educate providers about best practices through training, provider newsletters or Web site		*				
Reviewer Comments:						

Additional Information

Overall Reviewer Assessment (explain any “no” items and how the MCO should address these)