

	“Essential” Recommendations
2 CC-CR-2	MCO shall attempt to contact all new members for whom an initial screen was not conducted by the enrollment broker, within 30 days of enrollment to administer the initial screen.
3 CC-CR-3	MCO shall have meaningful consumer participation in health plan decision-making and advisory processes.
5 CC-SR-2	The state should develop a standardized initial health screen to determine any disabilities, chronic conditions, or transitional services needs.
6 CC-SR-3	The state should provide health plans with member-specific, historical fee-for-service, claims information, and pharmacy data for members who are entering Medi-Cal managed care as well as for those currently in the program who are accessing carved-out services.
11 ES-CR-1	The MCO shall work with FFS providers (for people newly enrolled in managed care) or other MCOs (for people switching between MCOs) to ensure that: <ul style="list-style-type: none"> • An ongoing course of treatment is not interrupted or delayed due to the change to new providers; and • Medical record information is transferred to new providers in a timely fashion.
13 ES-CR-3	Written materials must be available upon request in alternative formats in a timely fashion.
14 NC-CR-1	The MCO shall identify areas of provider accessibility for members with disabilities and chronic conditions. The MCO will use the DHCS-enhanced FSR (<i>facility site review</i>) tool, along with additional information related to physical and non-physical accommodations.
15 NC-CR-2	The MCO shall submit policies and procedures on how it will enable members to access services. These policies shall address: <ul style="list-style-type: none"> • Lifting policy and procedure; • Flexible appointment time and length; • Provision of service in alternative locations; and • Use of identified facilitators

18 NC-CR-5	The MCO shall use the relay service (711 or TTY) for people with speech disabilities and for the deaf and have mechanisms to ensure that members can be responded to within required telephone and after-hour calls standards.”
25 BM-CR-3	The MCO shall arrange for the provision of specialty services from specialists outside the network if unavailable within the MCO’s network, when determined medically necessary.
26 CM-CR-1	MCO shall use the specified definition for care management
27 CM-CR-2	The MCO shall provide care management for members who are identified through the care management assessment mechanisms as having the need for greater care management than can be provided by the PCP.
29 CM-CR 4	The MCO shall maintain procedures for identifying members for care management
30 CM-CR-5	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.
32 CM-CR-7	The MCO shall submit policies and procedures describing how it will assist members in coordinating out-of-plan services, particularly for people who receive services from programs carved out of the capitated managed care program.
34 QI-CR-1	The MCO shall use member data to identify and stratify disabilities and multiple chronic conditions to develop and implement targeted quality improvement activities and interventions.
35 QI-CR-2	The MCO shall stratify utilization data to capture statistically significant results for subcategories of its Medi-Cal enrollees. Sample size, sample selection,* and implementation methodology shall be determined by DHCS, with MCO input, to assure comparability of results across MCOs. *The MCO may have to over sample its data to yield a statistically significant result.”
42 QI-SR-2	DHCS should stratify risk-adjusted utilization data to capture statistically significant* results for all categories of Medi-Cal enrollees and provide the results to MCOs in the aggregate form.

<p>46 PM-CR-1</p>	<p>The MCO shall stratify the following measures to capture statistically significant results for its SSI-eligible members:</p> <ul style="list-style-type: none"> • Appropriate use of medication for people with asthma; • Breast cancer screenings; • Cervical cancer screening; and • Retinal eye exam for people with diabetes (currently only required of COHS plans).”
<p>47 PM-CR-2</p>	<p>MCOs shall collect the following HEDIS measures in addition to its EAS reporting requirements:</p> <ul style="list-style-type: none"> • Comprehensive Diabetes exam (retinal eye exam, HBA1c test, LDL screening and neuropathy screening); • Antidepressant medication management; • Controlling high blood pressure; • Annual monitoring of patients on persistent medication; • Cholesterol Management for patients with Acute Cardiovascular Conditions; • Beta-blocker treatment after a heart attack; and • Persistence of beta-blocker treatment after a heart attack.”
<p>49 PM-SR-2</p>	<p>In year one, the DHCS, working with key stakeholders, should develop a standardized statewide consumer satisfaction survey tailored to identify issues important to people with disabilities and chronic conditions.</p>
<p>51 CCO-SR-1</p>	<p>The legislature should require the CHHSA departments with oversight of the carve-out service system to develop and execute a reciprocal, state-level, interagency MOU.</p>
<p>53 CCO-SR-3</p>	<p>CHHSA shall identify and clearly delineate the appropriate party for claims payment”.</p>