

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

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I. INTRODUCTION

This report provides a set of recommended health plan performance standards and measures that can improve how people with disabilities and chronic conditions receive services through the Medi-Cal managed care program.¹ The recommendations represent essential building blocks for measuring and improving quality, particularly if state policy makers approve the proposed large-scale expansion of mandatory managed care for people in disability-related eligibility groups. In addition, the recommendations provide an essential tool for California policy makers and program officials to ensure that Medi-Cal funds are spent efficiently and that limited state resources are used most effectively.

A. Background

“Disability is not an illness. The concept of health means the same for persons with or without disabilities: achieving and sustaining an optimal wellness—both physical and mental—that promotes a fullness of life.”²
—Dr. Richard H. Carmona, U.S. Surgeon General

In California, there are about one million people with disabilities enrolled in Medi-Cal. They account for 40 percent of Medi-Cal expenditures, but represent only 14 percent of the program’s beneficiaries.

People who qualify for Medicaid based on eligibility for SSI are extremely heterogeneous; there is no one category that can be labeled as “the disabled.”³ People with disabilities have a wide variety of physical impairments, mental health, and developmental conditions, and other chronic conditions. In addition, they:

- Are increasing in numbers and account for a growing percentage of Medicaid expenditures;⁴
- Have limited access to primary and preventive care;⁵
- Use a complex array of specialty, ancillary, and supportive services;⁶
- Are much more likely to have multiple chronic or complex conditions;⁷ and
- Experience a dizzying array of physical, communication, and program barriers.⁸

Table 1 provides examples of the most prevalent disabling conditions in the Medi-Cal program. The same disease can vary in intensity from person to person. People with chronic conditions (such as asthma, diabetes, congestive heart failure) can become disabled or be limited in the activities they can perform. As the number of conditions in a single person increases, so can service utilization and the need for care coordination. In addition, some beneficiaries with disabilities may require additional supports in order to access services (e.g., transportation, interpreters, and longer appointments).

Table 1. Types of Disabling Conditions Prevalent Among Medi-Cal Beneficiaries

Type	Examples
Physical	Loss of limb, paralysis, congenital conditions, organ dysfunction.
Sensory	Loss of vision, loss of hearing
Developmental	Mental retardation, cerebral palsy, autism, brain injury, epilepsy
Mental	Schizophrenia, bipolar disorder, depression
Other	HIV/AIDS, cancer, multiple sclerosis

Source: L. Chimento, et al. *Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for Service Systems* (Oakland, CA: California HealthCare Foundation, 2005).

Approximately 20 percent of Medi-Cal beneficiaries with disabilities are enrolled in managed care. The vast majority of those enrolled in managed care reside in one of the eight counties in California served by locally-controlled, not-for-profit County Organized Health Systems (COHS); however, some people with disabilities who reside in counties with the Two-Plan or Geographic Managed Care models have voluntarily enrolled in Medi-Cal managed care.

The Medi-Cal managed care program offers several potential benefits to beneficiaries with disabilities. Health plans are an accountable entity that provide additional health care supports not available to fee-for-service beneficiaries, such as care management and access to a “medical home” or designated primary source of care. In addition, research has shown that managed care can improve health outcomes compared to other systems. For example, the average annual rate of hospitalizations for ambulatory-sensitive conditions such as asthma, pneumonia, and hypertension – often referred to as “preventable hospitalizations” – is about 30 percent lower for managed care enrollees as compared to those in fee-for-service delivery system.⁹ This suggests that people with disabilities have better access to primary care in the managed care program than do beneficiaries in fee-for-service. However, in both managed care and FFS settings, Medi-Cal beneficiaries with disabilities report difficulty in finding physicians, communicating effectively with their providers, and with physical access.¹⁰

In January 2005, Governor Schwarzenegger proposed expanding mandatory managed care for people with disabilities beyond the eight counties in California served by County Organized Health Systems. The California HealthCare Foundation viewed the Governor’s proposal as an opportunity to foster a constructive dialogue among health plan representatives and consumer advocates, to improve the quality of care for people with disabilities and chronic conditions, and to establish better methods of measuring and monitoring health plan performance.

After conducting a two-month feasibility study, the California HealthCare Foundation (CHCF) contracted with three consulting groups to develop a set of comprehensive performance standards and measures for health plans serving people with disabilities. The project consultants also were charged with identifying strategies for better coordinating services that are “carved-out” of the health plan contracts, such as institutional and community-based long-term care, California Children’s Services (CCS), alcohol and substance abuse treatment, and mental health services. Project goals also included working with Medi-Cal program officials to develop a plan for monitoring health plan performance and an enhanced readiness assessment instrument.

The three consulting groups are the Center for Disability Issues and the Health Professions at Western University of the Health Sciences, the Center for Health Care Strategies, and The Lewin Group. These groups were selected by CHCF because of their experience working with state Medicaid programs and health plans to improve care for people with disabilities and chronic conditions, their expertise in federal and state Medicaid managed care rules and regulations, and their effective working relationships with consumers and consumer groups representing people with disabilities. Moreover, the resources of each group were needed to complete the first phase of this project – the development of contract standards and performance measures – within the timeframe established by CDHS.¹¹

As state policy makers consider increasing the number of people with disabilities and chronic conditions required to enroll in managed care, they have a unique window of opportunity to design and implement an effective program and greater accountability for how public funds are spent. Moreover, California is already third in the nation in the number of beneficiaries with disabilities enrolled in Medicaid managed care (Pennsylvania and New York are one and two respectively). A substantial expansion in enrollment would make California the state with the largest number of people with disabilities and chronic conditions enrolled in managed care. **Given the sheer size of the population, the mandatory nature of enrollment, and the magnitude of their care needs, California has a huge opportunity — and a daunting responsibility — to “get it right.”**

What does “get it right” mean? Getting it right means taking the time and energy to understand the strengths and improvement opportunities within the current managed care program, to learn from other states’ experiences, to further develop the infrastructure needed to support quality and access enhancements, and to develop standards that better reflect the characteristics of and needs of people with disabilities and chronic conditions.

B. Methodology

Research for this project included a multi-faceted approach, using both qualitative and quantitative analysis. The consultant team relied on previous work funded by CHCF, including prior work conducted by members of the consultant team.¹² The consultant team also conducted the following national research:

- Reviewed federal Medicaid managed care rules and requirements;

- Researched best practices of other state Medicaid managed care programs that serve similar populations (including Arizona, Maryland, Massachusetts, Michigan, New Jersey, New York, Oregon, Pennsylvania, Texas, and Wisconsin); and
- Reviewed Medicare Advantage rules released by the Centers for Medicare and Medicaid Services earlier this year.

In addition, California-specific research included:

- Reviewing data from a sample of Medi-Cal fee-for-service claims to assess diagnoses and service utilization trends;¹³
- Analyzing Medi-Cal’s current contract, relevant statutes, regulations, and policies;
- Determining whether other state Medicaid managed care contracts met or exceeded current California requirements; and
- Interviewing current California health plans for information regarding best practices among the current mandatory and voluntary Medi-Cal managed care programs (including CalOptima, Central Coast Alliance, Inland Empire Health Plan, Health Net, and Partnership Health Plan).

The consultant team also developed and facilitated an extensive process to solicit public input and feedback in eight areas: enrollment and member services, network capacity, accessibility, benefit management, care management, quality improvement, performance measurement, and coordination of carve-out services.¹⁴ This public input process included:

- Eight workgroups totaling over 100 California representatives from consumer organizations, health plans, health care providers, the California Department of Health Services and other state agencies, such as the Department of Rehabilitation, the Department of Managed Health Care, the Department of Mental Health, and the Department of Developmental Services. Most state agencies were “participant observers” in the workgroups except during the carve-out workgroup discussions, in which state agency representatives were full participants.¹⁵
- A 28-member advisory group comprised of a smaller number of the above California stakeholders.¹⁶
- A variety of web-based, telephonic, and in-person meetings to obtain feedback on the recommendations from interested parties who were not able to participate in either the workgroup or advisory groups.
- A review panel of nationally-recognized experts including health policy experts, managed care organizations, and state Medicaid officials from outside of California.

The report reflects the sometimes divergent and the sometimes convergent views of the disparate stakeholders. The stakeholders provided invaluable contributions and perspectives based on their experience. **However, ultimately, the recommendations included within this report reflect those of the consultant team.**

The report also highlights where specific recommendations are based on information from selected states and health plans that have experience with Medicaid managed care for the SSI population. However, the report does not provide a comparison of the proposed enhancements to the total number of states with similar standards, as this was outside the project scope.

Finally, the project primarily focused on the acute care needs of adults between the ages of 22 and 64 who qualify for Medicaid based on eligibility for Supplemental Security Income (SSI). Issues pertaining to children and seniors were addressed as they relate to non-CCS services, care coordination and the transition into and out of the Medi-Cal program. Irrespective of age, many people with disabilities and chronic conditions face similar health care issues and needs. The recommendations presented in this report can be used to inform and supplement the state's ongoing work in the areas of long-term care integration and children with special health care needs.

C. Building a More Effective Health Care Delivery System

The workgroup and Advisory Group discussions highlighted a variety of “key considerations” that the consultant team balanced in developing the final recommendations including:

- The potential costs (both time and money) of the recommendations versus the anticipated benefits;
- The need to hold both health plans and delegated medical groups accountable while proposing recommendations that were feasible and practical;
- The need to identify the minimum standards necessary for an expansion of mandatory managed care for individuals with disabilities and chronic conditions;
- The responsibility to ensure adequate standards that address the needs of people with disabilities and chronic conditions in a mandatory program without adding unnecessary complexity to an already-complicated system; and
- The balance between promoting innovation and plan flexibility versus the desire to standardize requirements and best practices across plans.

Overall, the consultant team tried to ensure that the performance measures and standards outlined herein are responsive to people with disabilities and chronic conditions and that the recommendations are enforceable, measurable, and reasonable in the overall context of the Medi-Cal managed care program.

The recommendations are geared more toward comprehensive standards that could be applied in a mandatory program. The consultant team believes that in a mandatory program, where choice may be more limited, where enrollment would be larger, and where plans have additional resources to invest in administrative infrastructure, more extensive standards and measures are both practical, desirable, and have the long-term potential to result in cost savings.

Throughout the project, both the consultant team and the Advisory Group also developed a set of guiding principles to help inform and shape the final recommendations. We hope that the California Department of Health Services, other state agencies, health plans, providers, and consumer organizations will work to:

1. Create a paradigm shift or systems view toward delivering quality health care to people with disabilities and chronic conditions and build the knowledge, skills, and infrastructure to do so.
2. Provide equality of opportunity for managed health care services, including genuine, meaningful and effective access to facilities, equipment, materials, treatment, and services.
3. Promote a consumer/patient/family-centered approach to care delivery that is holistic, culturally competent, individually tailored, and empowering to ensure appropriate and coordinated health care services. Consumers should have choice of providers and could help navigate, self manage, and direct their own care.
4. Emphasize the importance of maintaining and improving functional status, quality of life, and wellness for people with disabilities and chronic conditions so they can live independently and fully participate in their education, employment, and communities.
5. Build the knowledge and understanding of health care professionals regarding the complex and multi-faceted needs of people with disabilities. Foster disability literacy and competency and build immediate and ongoing professional development opportunities and capacity.
6. Create a flexible care model that can adapt to the different needs of people with disabilities and chronic conditions, but that coordinates all services, including primary, specialty, ancillary, behavioral health, and long-term care. Coordination of services would include both medical and non-medical care.
7. Use public resources more effectively by correcting under utilization, over utilization, and misuse of services.
8. Build accountability into the health care system at the state, plan, provider, and consumer level.

D. A Necessary State Infrastructure

Contract performance standards and measures allow the state to clearly define what and how it wants to purchase managed health care services and provides a vehicle to ensure health plan accountability. However, enhancing such standards alone may not always be sufficient to overcome fundamental deficiencies in the health care marketplace and/or in the fee-for-service program. Specialty provider shortages, access to providers in rural areas, and limitations in data and information technology infrastructure are particular issues plaguing our health care system. In addition, when compared nationally, Medi-Cal ranks at or near the bottom in physician and health plan payment rates.

However, for the state to “get it right” it also needs to lay the groundwork for a successful managed care program. California has an opportunity to learn from the experience of other states, as well as its own past experiences implementing Medi-Cal managed care in 22 counties. These experiences suggest the following ingredients for success:¹⁷

1. Conduct key pre-implementation activities, such as health plan readiness assessments, training for enrollment broker and health plan staff, and a thorough review of state managed care materials. States often underestimate the amount of time and focus needed in the transition phase of mandatory managed care for people with disabilities and chronic conditions.
2. Analyze utilization, expenditure, and clinical data to thoroughly understand the patient population, their patterns of care, and the mix of services used. As a pre-implementation activity, the state should provide an aggregate analysis to the health plans to assist in the development of health plan networks, care management programs, and a clinical quality improvement infrastructure. The state also should develop an infrastructure to provide ongoing analysis and feedback to the plans.
3. Define the system of care the state wants to create and purchase. The state needs to articulate a clear vision of care for people with disabilities and chronic conditions and translate this vision into state public policy contract requirements. Improving how the state purchases managed care can lead to better accountability and improved outcomes.
4. Balance expectations with adequacy of rates. The state should develop actuarially sound rates, and rates should be increased regularly to reflect the growing cost of serving people with disabilities. In addition, rates should be risk-adjusted based on health and functional status. Risk-adjusted systems have become more widely used in Medicaid managed care programs offering California a wealth of experience upon which to draw.
5. Make the current system of carve-out services easier to understand. The current Medi-Cal managed care program carves out multiple services (including behavioral health, California Children’s Services, alcohol and drug, and long-term care services), which can create confusion among patients, providers,

health plans, and state agencies. It also can create incentives for cost-shifting and other inefficiencies. If California chooses to keep the current fragmented design, it should clarify coverage and payment policies among relevant state agencies and the health plans.¹⁸

6. Recognize the state resources necessary to build the infrastructure needed to serve people with disabilities and chronic conditions. The state will need to invest resources (including fiscal, human resources, and time) into building the capacity of other managed care contractors, including the state enrollment broker and the External Quality Review Organization (EQRO) and of state staff.
7. Recognize the health plan resources necessary to build the infrastructure needed to serve people with disabilities and chronic conditions. Health plans will need to invest in member services and network enhancements, care management and disease management programs, and quality improvement infrastructure. Capitation rates and savings assumptions should factor in such necessary building blocks without taking funds away from patient care.
8. Publicly report on the performance of both the fee-for-service and managed care programs for people with disabilities and chronic conditions and for all individuals covered by Medi-Cal. Accountability at the state level can be fostered by transparency of information to consumers, stakeholders, and policy makers. The state should create a more robust and periodic public disclosure process for a set of key performance indicators for both its fee-for-service and managed care programs.
9. Ensure continuity of care during transition from fee-for-service to managed care. Because people with disabilities and chronic conditions have often spent years finding providers particularly specialists with the appropriate clinical knowledge and disability competency, maintaining the patient-provider relationship should be a high priority. Providing member-level service data to health plans during the enrollment process can help ensure such continuity of care.
10. Involve a large range of stakeholders in the planning and development of a managed care program, including consumers, family members, consumer advocates representing a broad array of disability and chronic care groups, health plans, provider organizations, and primary care, specialty, and ancillary providers.

E. Organization of the Report

The report is organized into chapters, reflecting recommendations for performance standards in each of eight key contract areas:

- Cross-Cutting Issues

- Enrollment and Member Services
- Network Capacity and Accessibility
- Benefit Management
- Care Management
- Quality Improvement
- Performance Measurement
- Coordination of Carve-Out Services

Each chapter provides a detailed explanation of each recommendation, its rationale, and examples from other states and/or the current Medi-Cal contract. In addition, cost implications are highlighted for each recommendation. Cost is an important issue in every state, but especially so in California, given its historically low Medi-Cal managed care and fee-for-service payment rates, and its recent history of little or no health plan rate increases during a period in which health care costs have grown annually at a double-digit pace. A comprehensive evaluation of the cost implications for the proposed recommendations was outside the scope of the project; however, the discussion of cost implications is included in this discussion of each recommendation based on the consultant team's knowledge and experiences with other states that have implemented similar strategies and health plan operations.

The concluding chapter provides the project's next steps and a summary table of the recommendations. The summary table provides a priority ranking for each recommendation. The criteria for the rankings is as follows: (1) **essential** requirements to have in place for Medi-Cal managed care models that mandate enrollment of people with disabilities and chronic conditions, including some current counties as well as proposed expansion area; (2) **important** provisions to bring California in line with other state Medicaid managed care programs and to have in place for a mandatory program, but are not necessarily for the initial transition period; and (3) **ideal** recommendations that would move California closer to a system that embraces the guiding principles outlined in the summary chapter, that could catapult California as a national leader in serving people with disabilities and chronic conditions. These third level rankings also include recommendations that could be implemented over a longer time horizon than those in the first two groups (essential and important). The distinctions between essential, important, and ideal could help CDHS prioritize the numerous recommendations included in this report.

This report provides a road map of operationally-oriented strategies that can have a real impact on care delivery for people with disabilities and chronic conditions. The individual recommendations and the recommendations in total represent a significant opportunity to create a more accountable health care system and to improve beneficiaries' experiences with the Medi-Cal managed care program.

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- ¹ Performance standards and measures are also referred to as contract requirements. Both are used interchangeably throughout the report.
- ² US Department of Health and Human Services, *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities*. (Rockville, MD: Office of the Surgeon General, 2005).
- ³ Also referred to as the aged, blind, and disabled (ABD) population.
- ⁴ J. Holahan and A. Ghosh. "Understanding the Recent Growth in Medicaid Spending, 2000-2003." *Health Affairs Web Exclusive*, 26 January 2005. [http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52.\(10 October 2005\)](http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52.(10 October 2005)).
- ⁵ L.I. Iezzoni, R.B. Davis, J.Soukup, B. O'Day, "Satisfaction with Quality and Access to Health Care Among People with Disabling Conditions." *International Journal for Quality in Health Care*, 14, no.5 (2002): 369-381.
- ⁶ J. Crowley and R. Elias. *Medicaid's Role for People with Disabilities*. (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2003): 21-26.
- ⁷ Partnership for Solutions, "Chronic Conditions: Making the Case for Ongoing Care," December 2002, <http://www.partnershipforsolutions.com/dms/files/chronicbook2002.pdf> (26 September 2005).
- ⁸ Premo, B., et al. *Adults with Disabilities in Medi-Cal: The Beneficiary Perspective*. (Oakland, CA: Medi-Cal Policy Institute, 2003).
- ⁹ Bindman, A., et al. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*. (Oakland, CA: California HealthCare Foundation, 2004).
- ¹⁰ L. Chimento, M. Forbes, A. Sander, J.Kailes, B.Premo, C. Richards and C. Perrone, *Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care and Fee-for-Service Systems*. (Oakland, CA: California HealthCare Foundation, 2005).
- ¹¹ For a more detailed summary of this project, see California HealthCare Foundation: "Medi-Cal Beneficiaries with Disabilities: Improving Quality and Accountability," August 2005.
- ¹² Premo, B., et al. op. cit.
Bindman, A., et al. op. cit.
L. Chimento., et al. op. cit.
California HealthCare Foundation. Op. cit.
- ¹³ The Lewin Group analyzed data from the 5% sample of Medi-Cal fee-for-service claims from fiscal year 2001.
- ¹⁴ See Appendix A for a description of each workgroup.
- ¹⁵ See Appendix B for a list of Workgroup participants.
- ¹⁶ See Appendix C for a list of Advisory Group members.
- ¹⁷ N. Highsmith and S. Somers, "Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States." (Oakland, CA: Medi-Cal Policy Institute, 2003).
- ¹⁸ This paper does provide recommendations for the state in the area of carve-out services (see Chapter 8). This was a specific focus of the public input process and research contributing to this report.

II. RECOMMENDATIONS

1. CROSS-CUTTING ISSUES

A. Introduction

Several recommended performance standards cut across several issue areas. These include:

- Training for providers and MCO staff in the areas of disability including disability literacy and competencies, health care needs, and accessibility rights;
- Identifying the specific needs of members and communicating that information to MCOs and providers in a timely manner;
- Assisting members and providers in understanding the different patient and provider appeals processes available to managed care enrollees;
- Establishing processes for consumer input and participation, and assistance for consumers with navigation of the managed care system; and
- Ensuring that MCOs are complying with new performance standards and contract requirements.

All of these elements will help create an accessible and responsive system, not only for future managed care enrollees but also for those who are already enrolled in Medi-Cal managed care on a voluntary or mandatory basis. MCOs will need to take an active role in making change in the daily operations of provider networks, member services, and quality improvement systems to better meet the health care needs of people with disabilities and chronic conditions. The state will need to take a leadership role in setting expectations for MCO performance and coordinating efforts with other governmental entities to exchange important information on services provided to MCO members by outside entities. Because these issues require close cooperation on the part of the California Department of Health Services and the contracted MCOs, the recommendations included below are presented jointly.

B. Key Recommendations for the Medi-Cal Managed Care Contract and for the California Department of Health Services and Other State and Local Agencies

1. *Training*

When visiting a health care provider, a person, without regard to disability status, should reasonably expect that the provider has expertise and knowledge to respond to articulated health concerns.¹⁹ MCOs are required by contract to ensure that all providers receive training about the Medi-Cal managed care plan and relevant federal and state regulations, in order to be able to understand and fully comply with the program requirements. The current Medi-Cal managed care contract does not contain language requiring clear baseline expectations around disability competency and sensitivity training for health plan staff or providers. Training requirements for MCO staff and network providers could be strengthened in the area of disability literacy and competencies, rights, and the needs of

people with disabilities and chronic conditions. Disability literacy involves understanding basic disability concepts such as the types of activity limitations people with disabilities have, the importance of sensitive etiquette practices, potential personal prejudices, how to be aware of and mitigate them, and how to develop and implement procedures and policies that accommodate people with disabilities. Disability competencies includes applying disability literacy through a set of compatible behaviors, beliefs, attitudes, values, practices, skills, and policies to enable the system, organization, and providers to work effectively with a diverse population of people with disabilities.

Establishing training that is consistent across health plans will move the system forward by establishing a common vocabulary and knowledge base on disability issues. MCO training should be tailored to address specific staff responsibilities (member services, care coordinators, facility site reviewers). Training could be developed by either the MCO, CDHS, or both, and could include people with disabilities and chronic conditions in the development process. Many states currently require MCOs to provide training to health plan staff and, in some cases, to providers about specific aspects of the program (e.g., any unique Medicaid requirements regarding preventive care for children). The states researched for this project do not require disability literacy and competency training, although some Medicaid MCOs may include this as part of routine staff and provider training activities. However, if the proposed expansion is implemented in California, the state should ensure that providers are trained to better serve such large numbers of people with disabilities and chronic conditions. The training may create some new costs for MCOs, which are already required to conduct provider and staff training in other areas.

In addition, state agencies providing carve-out services should be required to implement training for staff in the areas of disability literacy and competencies, rights and the needs of people with disabilities and chronic conditions.

Recommendations for MCO Contract (CC-CR-1)

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

- Various types of chronic conditions and disabilities prevalent among Medi-Cal beneficiaries;
- Awareness of personal prejudices;
- Legal obligations to comply with the Americans with Disabilities Act (ADA);
- Scope of benefits, including range of carve-out services, how to refer people to services covered by other state agencies, and information on the availability of standing referrals for specialists and specialists as Primary Care Providers (PCPs);
- Definitions and concepts such as communication access, medical equipment access, physical access, and access to programs; and

- The types of barriers that adults with physical, sensory, communication disabilities, developmental or mental health needs face in the health care arena and the resulting access and accommodation needs.

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

Recommendations for State Agencies (CC-SR-1)

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

2. *Initial Screen*

California currently requires plans to “schedule and provide an initial health assessment (complete history and physical examination) to each Member within 120 days of the date of Enrollment, unless the Member's Primary Care Physician determines that the Member's Medical Record contains complete and current information.” There is no requirement for the MCOs or enrollment broker to conduct an initial, non-clinical screen of all members to identify any access or accommodation needs, language barriers, or other factors that might indicate that the new member requires additional assistance from the health plan. An initial screen could identify members who have complex or serious medical conditions and identify essential health care needs that may require an expedited appointment with an appropriate provider. The initial screen could be conducted in person, by phone, or by mail.

Many states require non-clinical MCO staff to conduct an initial screening within a shorter timeframe to identify needs for medical services and care management and make appropriate referrals. For example, Pennsylvania’s enrollment broker asks a question related to specific needs/disabilities during the enrollment process, and transmits any responses provided by new enrollees to the MCO and state. Texas includes five questions for children and three for adults, in both pre-enrollment telephone contacts and in the mailed enrollment form. This information is recorded in the electronic enrollment file that is sent to the MCO. Maryland uses an extensive list of questions regarding health status and accommodation and wrap-around service needs.

During the public input process, there was a strong consensus that an initial screen is an essential part of the enrollment and transition process for people who are new to managed care. The screen will help ensure that those who are in ongoing treatment receive assistance in accessing appropriate care within the health plan and avoid disruptions. A screen also will provide information to the health plans so that they can better communicate with members who face a variety of accommodation and accessibility challenges. Because of the time and effort needed for the enrollment broker (in counties

where enrollment is conducted by a third party) and health plans to administer the screen to all new enrollees, the state will need to provide funding for this activity. The cost associated with implementing this recommendation may be substantial in the aggregate (for the state), especially during an initial transition period from fee-for-services to managed care, but low cost on a per member basis.

The state should develop a standardized initial health screen to determine any disabilities, chronic conditions, or transitional services needs. The enrollment broker should attempt to conduct an initial screen of all new managed care enrollees and transmit the findings from the screen to the selected (or assigned) health plan. If the enrollment broker is unable to complete the screen, or if the member does not contact the broker and is assigned to an MCO, then the MCO should attempt to conduct the screen. The screen should be short, no more than a few questions, and should be worded in a concise, clear, and consumer-friendly way. MCOs and the enrollment broker can work with local organizations with experience serving persons who have disabilities and chronic illnesses to identify ways to locate and contact new enrollees. In the COHS counties, where there is no enrollment broker, the health plan should be tasked with conducting the initial screen and funded appropriately by the state for this activity.

Recommendations for State Agencies (CC-SR-2)

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

Recommendations for MCO Contract (CC-CR-2)

The MCO shall attempt to contact all new members for whom an initial screen was not conducted by the enrollment broker, within 30 days of enrollment to administer the initial screen. The purpose of the initial screen is to identify: (1) members who have complex or serious medical conditions; (2) essential health care needs that may require an expedited appointment with an appropriate provider; (3) any access or accommodation needs, language barriers, or other factors that might indicate that the new member requires additional assistance from the health plan; and (4) any caregivers or other decision-makers involved in the member's care. If the MCO is unable to complete the screen within three attempts (either at different days/times or through different mechanisms such as mail, telephone, in person visit) within 90 days, or in the event that a member refuses to participate in a health screen, the MCO shall document that the screen was not completed and encourage the member to schedule an appointment with his or her PCP.

3. *Information Sharing*

Many people with disabilities and chronic conditions who may enroll in Medi-Cal managed care plans are currently enrolled in the Medi-Cal fee-for-service program, and program officials have access to medical claims information on these beneficiaries' diagnoses, utilization patterns, and existing provider relationships. These data should be provided to managed care organizations on an aggregate basis so that health plans can develop adequate provider networks and benefit management programs. Proving this information to health plans on a member-level, when a beneficiary joins or is assigned to a health plan, would enable the health plans to reach out to new enrollees and provide assistance or facilitate provider linkages. Some leading states provide fee-for-service data to health plans for these purposes. For example, New Jersey's fee-for-service claims processor provides the state with fee-for-service claims data detailing how the member has accessed the system over the past two years. The state then packages this administrative information and sends it to the member's new health plan.

The state should provide health plans with data regarding members who are entering Medi-Cal managed care from the fee-for service program. For new and current beneficiaries, the state also should provide health plans with historical data regarding the use of carved-out benefits. The data should include member-specific fee-for-service data as well as pharmacy data for members accessing services at other state agencies/carve-out entities (e.g., county mental health facilities, alcohol and drug programs, developmental disabilities, etc.). The state should ensure that any data transfer is compliant with confidentiality laws and regulations. The transfer of these data is an essential activity in ensuring the members with ongoing health conditions are transitioned into managed care with a minimum of disruption in their care.

Recommendations for State Agencies (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.

4. *Patient and Provider Appeals*

Many mechanisms are available to members should they choose to appeal a denial of health care services (e.g., internal plan review, Medi-Cal fair hearing, independent medical review). The options, however, can be confusing especially since some options preclude appeals through other mechanisms. For example, if an enrollee pursues an appeal through the State Fair Hearing process, he or she cannot then pursue the same appeal through the Department of Managed Health Care's (DMHC) independent medical review process. Compounding this challenge is the administrative burden associated with multiple appeals procedures for providers appealing on behalf of their patients, thus creating a potential disincentive for them to accept complex patients into their practice. Clarifying and improving these mechanisms is a concrete step the state can take to strengthen the Medi-Cal managed care program.

Recommendations for State Agencies (CC-SR-4)

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

5. *Consumer Participation*

As the number of people with disabilities and chronic illnesses enrolled in Medi-Cal managed care grows, there will be ongoing challenges and successes that should be openly discussed with stakeholders, including consumers, health plans, providers, and state agencies. The state should establish a process for engaging local representation to discuss issues, especially if additional enrollment is expected in particular areas. This may be through targeted focus groups or an Advisory Committee structure and should allow for the discussion of ongoing challenges and successes with stakeholders, including consumers, health plans, providers, and state agencies. Most states have included a process to gather public input during the design phase of a new program or major program expansion. This type of consumer feedback mechanism should ideally be maintained prior to and during a phase-in process to identify and respond to emerging concerns.

To ensure that health plan activities are relevant and appropriate for people with disabilities and chronic conditions, MCOs need to create avenues for direct consumer input into health plan operations. Although the current contract does require consumer participation, specifically: “Contractor shall form a Community Advisory Committee (CAC) ...[and] shall ensure that the CAC is included and involved in policy decisions related to educational, operational and cultural competency issues affecting groups who speak a primary language other than English.” However, the participation requirements are not specific to people with disabilities and/or chronic conditions. It is important that people with specific experience and expertise on disability issues are included in the MCO consumer participation processes, and this can be achieved at little cost to the health plans. Currently, several Medi-Cal MCOs already have mechanisms for obtaining and using member input. For example, Inland Empire Health Plan (IEHP) has an advisory group, conducts a telephone survey of members with disabilities, and holds focus groups and community meetings to gather input from members.

Recommendations for MCO Contract (CC-CR-3)

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

The MCO shall include people with disabilities or chronic conditions and disability specific advocates in its decision-making processes through methods such as participation on an advisory group, conducting focus groups of members with disabilities and chronic conditions, or creating a separate committee specifically for members with disabilities and chronic conditions.

The MCO community advisory committee should include representation from beneficiaries and advocates familiar with the disabilities and chronic conditions prevalent among the plan's membership.

Recommendations for State Agencies (CC-SR-5)

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

6. *Consumer Navigation*

As Medi-Cal begins to enroll more members with disabilities and chronic conditions who are not familiar with or do not have experience with managed care, the state should work to provide a method for members to understand and navigate the complex Medi-Cal system. The state currently has an enrollment broker to assist members with MCO selection via a telephone center, however to best serve people with disabilities and chronic conditions, the state may have to extend its reach into the non-profit social service system where these members are already being served. The state can do so by partnering with community-based organizations to assist members new to managed care with MCO selection, program education, and system navigation. Variations of this model are successfully operating in several states, including New Jersey, Indiana, and New York. For example, New Jersey has a health benefits coordinator that teaches consumers to navigate the managed care system. In the past, New Jersey used a vendor to act as the health benefits coordinator and work with beneficiaries, providers, and community-based organizations that interact with members on a day-to-day basis to improve their ability to navigate the managed care system.

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

- Develop partnerships with the existing non-profit social service system for people with disabilities and chronic conditions to “meet the members where they are” and provide them assistance with MCO selection, program education, and system navigation.
- Follow the best practices of existing models (for example, in New York City, the non-profit partners are expected to conduct monthly public outreach meetings to

ensure that they are providing Medicaid managed care system information to as broad an audience as possible).

- Work closely in partnership with the health plans. This partnership will ensure that the non-profit social service system and the health plans have a clear understanding of each other's role and facilitate a seamless transfer of members between systems (for example, if a member visits a non-profit for system education information and learn that they are already a member of an MCO, the non-profit will facilitate the transfer of the case to the MCO).

In addition, the state may want to consider whether it should require MCOs to make available an orientation for all new members (the orientation could take different forms, such as group sessions or outbound member phone calls). The orientation might include information about benefits, PCP selection, policies for obtaining medical services, enrollee rights, etc. Some California Medi-Cal MCOs already conduct orientation on a voluntary basis.

Recommendations for State Agencies (CC-SR-6)

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

7. *Audits and Oversight*

Currently, the Audits and Investigations branch of CDHS is responsible for monitoring MCO compliance with the Medi-Cal managed care contract requirements. This branch oversees the fiscal integrity and quality of care for all Medi-Cal beneficiaries, not just those enrolled in managed care. The Audits and Investigations branch conducts a comprehensive audit of each health plan's policies, procedures, and operations every three years (this is generally done in conjunction with the Knox-Keene audit conducted by the Department of Managed Health Care). The audit, which is based on each plan's contract requirements, covers six areas (utilization management, continuity and coordination of care, access and availability, member rights and responsibilities, quality management, and administrative and organizational capacity) through a combination of desk audits, on-site interviews, and reviews. If certain areas are found non-compliant, the health plan must submit a corrective action plan to Audits and Investigations. A final report is then sent to the Medi-Cal Managed Care Division (MMCD), which must follow up with the plans and issue sanctions, if any. MMDC, however, has little input on the audit tool design and is not involved in the process until the report is complete.

During the workgroup process, some participants noted the importance that contract compliance and monitoring process plays in ensuring that contracted MCOs meet the program requirements. Others, however, expressed concern that the audit should be designed to assess compliance in a meaningful way that addresses the intent of the contract requirements and performance standards. Many other states use a quality improvement organization or other third party to conduct MCO contract compliance audits. These states

report that entities with experience in managed care operations, are better able to assess the extent to which the operations and outcomes are compliant with the intent of the contract provisions, instead of merely ensuring that written policies and procedures are compliant with the letter of the contract. Many states also involve managed care policy staff in the development or review of audit tools to ensure that auditors are appropriately interpreting contract requirements before applying the audit standards to the MCO operations and policies. This can help minimize the need for unnecessary corrective action plans and help keep the focus on the state's purchasing goals.

Recommendations for State Agencies (CC-CR-7)

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

2. ENROLLMENT AND MEMBER SERVICES

A. Introduction

The process of enrolling new members into 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, getting approval for care, getting assistance in coordinating care, and accessing accommodation or other support services. The state (and its agents, including the enrollment broker) and MCOs must work together to make the transition to managed care as seamless as possible and to support managed care enrollees. In particular, MCOs should adequately address that the primary concern of people with disabilities and chronic conditions moving from FFS to managed care—the potential loss of their existing and critical network of services—is managed effectively.

The following key values were articulated during the public input process:

- Staff training serves as a foundation necessary to ensure that people with disabilities and chronic conditions are able to access timely and appropriate services.
- Group needs assessment and disability literacy competency are fundamental to the ability to communicate and respond to the unique needs of beneficiaries with disabilities and chronic conditions.
- The assignment of a PCP (in the event the member does not select one upon enrollment) should take into account the physician’s experience with people with disabilities and chronic conditions, the accessibility of the office, and the ability and willingness of the office to accommodate specific needs.

The member services function has a crucial impact on members’ experiences with an MCO, because most members will 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 compared to those currently used for the Temporary Assistance to Needy Families (TANF) populations. The needs and barriers are different for this group of members and the manner in which information is disseminated requires some discussion and thought.

Below are several recommendations for the Medi-Cal managed care organizations, which are based on key considerations. Many of these changes build on the current Medi-Cal contract, which already contains many provisions regarding MCO and understanding of groups with different characteristics from “traditional” MCO enrollees, such as diverse cultural and linguistic groups of people. In addition, some of the recommendations are based on activities and policies that are not currently contractually required but have been

adopted by Medi-Cal MCOs because they are good business practice and help MCOs keep members healthy and avoid costly problems.

Communication with members is a critical aspect of enrollment and member services. The current Medi-Cal contract includes strong requirements for MCOs to provide information in alternative formats in both medical and non-medical settings. All states have similar requirements. For example, MCOs must provide beneficiaries with 24-hour oral interpreter services, either through interpreters or telephone language services, at all key points of contact:

- Medical care settings such as telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
- Non-medical care settings such as member services, orientations, and appointment scheduling.

The MCO must provide, at no cost to Medi-Cal members, “oral interpreters, signers, or bilingual providers and provider staff at all key points of contact,” and “Telecommunications Device for the Deaf (TDD).” However, the contract does not specify which auxiliary aids or services MCOs should use to communicate with members with disabilities or those who have conditions that require interpretation. In addition, requirements regarding alternate formats and interpretation services are not specified consistently throughout the contract.

There are no recommended contract changes for three key member-related aspects of the Medi-Cal managed care contract: marketing, member rights, and health education. The current contract language is adequate, particularly for marketing requirements. To the extent that additional member rights or responsibilities are identified that are particular to members with disabilities or chronic conditions, these should be added to the list. In addition, MCOs should develop health education programs, services, and resources that include findings from the group needs assessment that includes consideration of the needs of people with disabilities and chronic conditions.

B. Key Recommendations for the Medi-Cal Managed Care Contract

Summary Recommendations

Facilitate provider transition at enrollment.

Provide support for members on a systemic basis.

Provide written materials and web-based information in formats accessible to all members.

Implement mechanisms to identify and respond to people who need alternative communication approaches.

1. Provider Transition at Enrollment

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. Many states, including California, allow people to apply for exemption from managed care enrollment under certain conditions, and usually for a limited period of time (e.g., 12 months). However, a number of states require MCOs to provide continuity in the care of new members who have been treated by specialty care providers or whose health could be placed in jeopardy if care is disrupted or interrupted when transitioning from fee-for-service into managed care. California, like other states, has contract provisions for the transfer of members' care in the event the MCO contract is terminated or if a provider leaves the MCO network.

For example, Minnesota requires MCOs to provide enrollees with medically necessary covered services that an out-of-plan provider, another MCO, or the state had authorized prior to enrollment in the MCO. Texas requires each MCO to pay a member's existing out-of-network providers for covered services until the member's records, clinical information, and care can be transferred to a network provider. The federal government requires states that restrict enrollment to a single MCO in rural areas to transition members to an in-network provider within 60 days if the member's current provider does not participate in the managed care plan. This includes allowing the member to continue seeing the non-network provider, and requiring the MCO to reimburse that provider, during the transition period.

The current Medi-Cal contract specifies transition requirements in the event the MCO contract is terminated (i.e., the MCO must assist CDHS in the transition of members, and in ensuring, to the extent possible, continuity of member-provider relationships). However, it does not delineate specific requirements for transitioning a member's care upon enrollment in managed care from fee-for-service. During discussions with staff from several California MCOs, it appears that most MCOs 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. Although, MCOs are not currently contractually required to do so by CDHS, it is not anticipated that this requirement will add substantial new costs to the MCOs.

In addition, the current Medi-Cal contract has some provisions for the reimbursement of non-network providers when managed care enrollees are allowed to access these providers. For example, Medi-Cal managed care enrollees are currently allowed to self-refer to certain types of non-network providers, such as Indian Health Service facilities, at any time and other certain other types of providers, such as certified nurse midwives, if those providers are not available through the MCO's network. The contract allows MCOs to pay these non-network providers at the prevailing Medi-Cal fee-for-service rate. The same type of provision could apply to members transitioning into the managed care system from FFS when his or her provider is not part of the managed care network.

Recommendations for MCO Contract (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:

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

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

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

2. *Medi-Cal Member Advocacy*

Member advocacy is an important health plan function, since people with disabilities and chronic conditions have significantly different needs than the general population and can easily be overlooked. Some states require MCOs to provide a designated SSI member services representative, member advocate, or case manager/care coordinator (in addition to other staff, who also must have training and the ability to respond to the concerns of members with disabilities and chronic conditions). This person has additional training and responsibilities focused on the needs of members with disabilities and chronic conditions, and serves as a linkage between members and MCO management.

The current Medi-Cal program does not require MCOs to employ a single person as a Medicaid member advocate, but many of these functions are performed by plan staff in different parts of the organization (e.g., member services, complaints, care management). Some Medi-Cal health plans have designated a community relations coordinator or disability specialist to address these issues. During the workgroup discussions, the group did not come to consensus on whether the member advocacy function should be vested in a single individual. Member advocates are available through other organizations, including private advocacy organizations, the Department of Managed Care Health Care's Office of the Patient Advocate, and CDHS. However, it is worth recognizing that in the contract the MCOs have a 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. It is not expected that creating a unified

policy to capture what are likely existing MCO policies and procedures in a single place will create significant new costs for the MCO.

Recommendations for MCO Contract (ES-CR-2)

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.

3. *Written Materials and Websites*

In general, the requirements for the content and format of Medi-Cal member materials are similar to the requirements in many other Medicaid managed care programs. 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 websites to be accessible to people with disabilities (at a minimum, the web site must meet the accessibility requirements in Section 508 of the 1973 Rehabilitation Act).

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. These handbooks need to be available in alternate formats upon request. MCOs also are required to provide health education materials for members. It is not currently required in California that all materials be provided in all formats, but MCOs must make educational materials available in alternate formats upon request.

Interviews with California consumers and discussions with workgroup members found that MCOs need to strengthen their ability to provide written information, including member services guides and websites, in accessible formats to include language that is clear and easy to understand.

Recommendations for MCO Contract (ES-CR-3)

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

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

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

During the workgroup process, participants suggested some ideas that CDHS may want to adopt to strengthen the enrollment and member services requirements for the Medi-Cal managed care program.

- ***Provider education:*** CDHS should include information on the linguistic and interpretation service requirements for emergency room providers in its provider educational efforts (e.g., through ongoing provider communications).
- ***Group needs assessment:*** California currently has a unique contract provision that requires plans to conduct a group needs assessment, using multiple data sources, methodologies, and techniques to identify the health education, cultural, and linguistic needs of members. The findings are then used for continuous development and improvement of health education and cultural linguistic programs and services. CDHS has provided MCOs with a letter describing what should be addressed in the group needs assessment. CDHS could develop additional guidance for MCOs, suggesting that they include identification of health education and cultural and linguistic needs of members with disabilities and chronic conditions. It is also important to ensure that the assessment is conducted using methodologies that allow for input from members with communication and cognitive impairments, including input from caregivers or designated representatives if necessary.
- ***Member materials:*** The state could provide a standard Medi-Cal managed care handbook using consumer-friendly language (similar to the Healthy Families handbook) that all MCOs could adopt as a base.

3. NETWORK CAPACITY AND ACCESSIBILITY

A. Introduction

One of the key differences between the Medi-Cal fee-for-service program and the Medi-Cal managed care program is the use of and accessibility of physician networks. That is, unlike the fee-for-service program that allows beneficiaries to see any provider who participates in Medi-Cal, managed care organizations generally limit access to a pre-selected, credentialed network of providers that represent the range of services and geographic areas covered by the MCO's contract with the state. Because people with disabilities and chronic conditions have often spent years finding providers with the appropriate clinical knowledge and disability competency, the composition and adequacy of the managed care provider networks is a priority area.

The values the workgroup took into consideration while developing recommendations include the following:

- Real access to providers, including both physicians and others who provide services for people with disabilities and chronic conditions;
- Clearly stated definition(s) of accessibility and what this means for people with disabilities and chronic conditions;
- Sufficient number of physicians and other providers with relevant experience and expertise serving people with disabilities and chronic conditions;
- Flexibility for health plans to be creative, particularly in creating care teams and non-traditional PCPs;
- Ability to maintain existing patient-physician relationships; and
- Increased quality of care.

Within these values, the following are areas of significant importance that should be carefully considered when people with disabilities and chronic conditions are served through a managed system of care.

Role of the specialist as a primary care physician (PCP). As the number of members with disabilities and chronic conditions increases, more members may request specialists as PCPs as their care necessitates an ongoing relationship with a physician who has focused expertise and can provide care beyond what a PCP may be able to manage. However, specialists may not be able to take on the full range of PCP responsibilities required by Medi-Cal due to capacity/capability concerns, particularly the preventive and routine assessment components of a patient's usual primary care. A member, however, still needs both the preventive and focused/specialized care of both the PCP and specialist. It is important to note that while the member may use the specialist's services on a more frequent basis, the PCP still plays an important role in the member's overall care. This type of relationship still values a "medical home" (primary source of care), but modifies the role of the specialist and PCP so that the member is the center of a care coordinated model.

Broad access to needed specialists and ancillary providers. It is important that the MCO support access to needed specialists through robust networks, standing referrals to specialists, and referrals to out-of-network providers when necessary. Although the current Medi-Cal managed care contract allows or requires all of these concepts, there is a need to broaden the language beyond what exists currently in the contract, e.g., “Contractor shall arrange for standing referrals to specialists.” For example, plans should specify when the arrangements shall be made, under what kinds of circumstances, how providers will be educated about these provisions, and how members will be informed about their choices. In addition, access to durable medical equipment (DME), labs and screening procedures are considered to be a “provider” very much in the same context as a physician or hospital is a provider. For people with disabilities and chronic conditions, availability of and access to equipment and diagnostics is considered a vital component of the network.

Program access. Accessibility is a broad reaching concept, touching all aspects of MCO operations. MCOs will need to take an active role in fostering change in the daily operations of not only provider networks, but also member services and quality improvement systems to better meet the health care needs of people with disabilities and chronic conditions. The ultimate goal for accessibility is equal access, equal to the level of Medi-Cal beneficiaries without disabilities. *Equal access is not limited to physically accessible buildings (e.g., Section 504/ADA access), but also includes access to competent care, non-physical accommodations, and needed medical equipment.*

Training for providers. Providers need additional training on disability competency and clinical components (including education on secondary conditions) of care. Provider training also should include information on issues that play a significant role for people with disabilities and chronic conditions, such as the opportunity to use standing referrals for specialists and a specialist as a PCP. Training could be developed by the MCO, CDHS, or both, and could include people with disabilities and chronic conditions in the development process. CDHS has an opportunity to provide a leadership role in developing training materials that would promote consistent training throughout the state. Training opportunities may exist through a variety of methods such as newsletters, continuing medical education (CMEs), and qualified trainers. Recommendations for changes to provider and MCO staff training can be found in Section II-1, Cross-Cutting Issues.

Maintenance of provider relationships. Many fee-for-service beneficiaries have existing physician relationships, with unique needs and preferences underscored and understood by both individuals. The course of treatment usually takes time to build and refine as needed. Recommendations for an approach to transition care from non-network to in-network providers can be found in Section II-2, Enrollment and Member Services. In addition, CDHS can encourage current fee-for-service providers to participate in managed care networks in expansion counties, and provide fee-for-service providers with information on the contracted MCOs in current managed care counties.

In most cases, the activities of individual providers are governed by their contracts with the MCO, which must ensure that all contracted providers (individual and groups) comply with the terms of the MCO’s contract with the state. The recommendations below relate primarily to the contract between the MCO and the state. Specific requirements for

providers that could be included in the MCO-provider contract are described in various sections of this paper. As part of the readiness review process, the state should review sample contracts or copies of executed contracts between the MCOs and its network providers to ensure that all required provisions and contractual language is included.

B. Key Recommendations for the Medi-Cal Managed Care Contract

The current MCO contract already addresses many of the areas of importance, such as network composition (including safety-net providers), access to specialists, time and distance standards, PCP-to-member ratios, emergency services, credentialing, provider manual contents, and provider grievances. In these areas, the Medi-Cal contract contains standard provisions similar to those used in many other state Medicaid managed care programs. The network provisions are applicable to both people with and without disabilities and therefore changes are not recommended for most of the existing language. In other areas, slight modifications to contract language are recommended, for example to ensure that relay services for the deaf and people with speech disabilities are included in telephone procedures.

In addition, some new requirements are recommended for increasing accessibility of provider sites in MCO networks. The three specific recommendations are to: enhance the facility site review tool; require an MCO accessibility plan; and provide certain information on accessibility in the MCO's provider directory. The goals of these recommendations are to increase the level of awareness of accessibility issues in the current system, set goals for increasing accessibility in the managed care setting, and increase the ability of members to make informed choices when selecting provider sites. These recommendations do not represent a significant departure from what the state currently has in place, with the exception of new requirements for accessibility of provider facilities. This was largely adopted from a more detailed plan required by Appendix J of New York's Medicaid managed care contract.

Summary Recommendations

Increase accessibility of facilities in the network, over time.

Require MCOs to develop an ADA accessibility compliance plan.

Modify certain access requirements to be more responsive to the needs of members with disabilities and chronic conditions.

Include additional information on specialty providers in the provider network report.

Develop additional models for primary care and assignment of a "medical home."

1. Facility Site Review (FSR) for Primary Care Physicians

These recommendations represent significant changes to the current Medi-Cal managed care contract. The proposed ADA Accessibility Plan requirement is similar to a requirement in the New York Medicaid managed care contract, although the New York requirement is more extensive. The Accessibility workgroup, Advisory Group, and consultant team feel strongly that these changes are important to move the Medi-Cal managed care program in the direction of equal access to services for people with disabilities and chronic conditions. Some may require significant new investment by the state and MCOs, while others (such as the development of an annual plan) may be easier to implement.

Some of these requirements apply only to portions of the provider network. For example, currently a Facility Site Review (FSR) is only required for primary care physicians. However, using the current CDHS Site Accessible/Safety Survey Criteria contained in the FSR protocol, a primary care provider can meet all the elements and still be inaccessible to segments of members with disabilities and chronic conditions. The criteria lack detail and specificity, which is critical to determining whether facilities are accessible to people with disabilities and chronic conditions. For example, the only parking criteria is having “clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.” This item lacks detail regarding the presence of the required number of spaces, a van accessible space, and an accessible route to the primary accessible entrance. Another CDHS criterion is “wheelchair accessible restroom facilities or a reasonable alternative.” This item lacks detail regarding the presence of accessible amenities, e.g., clear opening of door; useable dispensers (toilet paper, hand towels, soap), faucets, door pulls, latches, and locking devices; clear floor space; and location of grab bars.

MCOs could partner together to complete these reviews and minimize the burden on providers. Several California Medi-Cal MCOs have conducted enhanced accessibility site reviews. For example, the Inland Empire Health Plan (IEHP) implemented the use of an enhanced accessibility checklist as part of the FSR process several years ago. In addition, L.A. Care Health Plan and Health Net are currently implementing a similar checklist.

In addition, the state may want to require MCOs to sample some proportion of specialty and ancillary providers to obtain baseline information on the accessibility of these provider sites and identify whether additional requirements are needed.

Recommendations for MCO Contract (NC-CR-1)

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

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

2. *Accommodation Policies*

Although accommodation policies are currently addressed in the Medi-Cal contract, the accessibility workgroup felt that the health plans should develop certain policies and procedures for ensuring accessibility across its network (a requirement which does not currently exist in the contract). For example, an MCO should have policies and procedures related to how it will locate services and provide transportation for a member in a wheelchair whose nearby mammography center does not have an accessible mammogram machine. Another example would be to identify and utilize an identified facilitator for people with developmental disabilities who may have unique preferences to be accommodated in advance and during a health care visit. Adoption of these policies should be relatively simple for MCOs and are considered a priority.

Recommendations for MCO Contract (NC-CR-2)

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

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

3. *MCO Reporting ADA Accessibility Plan for All Providers*

An annual MCO accessibility plan is a vehicle for health plans and CDHS to review continual improvements in plan operations to comply with the ADA. Although a new requirement, the workgroup felt strongly that the plan would provide MCOs the opportunity to set improvement goals and outline activities undertaken to meet such goals. The workgroup acknowledged that many of these systems changes would take years, but that an annual plan would show whether and what the type of progress is being made. 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, other state officials). This provision reflects important goals for the Medi-Cal managed care program and is an activity that MCOs can complete with a reasonable level of effort. However, it is important to recognize that achieving significant improvements will require the cooperation and efforts of many key players in the health care system.

Recommendations for MCO Contract (NC-CR-3)

The MCO shall file an annual ADA Accessibility Plan with CDHS.

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

The ADA Accessibility Plan must:

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

the accessibility and accommodation goals set out in the plan;

- Include a narrative explaining the organizational chart and describe the oversight and direction;
- Provide a summary report of data regarding complaints and grievances related to people with disabilities and chronic conditions;
- Be updated annually;
- Be made public and posted on the MCO's web site.

4. *Provider Directory*

Ultimately, consumers need information regarding accessibility to be able to make choices about their primary, specialty, and ancillary providers. Information collected through the FSR process or other vehicles should be shared with patients to help them make informed choices. Several California health plans have begun to share accessibility information with members because the plans think “it’s the right thing to do” and because it could increase enrollment in their health plan. To the extent that information is being collected through other mechanisms, providing this information to members can be done for little cost.

Recommendations for MCO Contract (NC-CR-4)

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

5. *Telephone Communication Requirements*

Under the current access requirements in the Medi-Cal contract, MCOs must maintain procedures for triaging members’ telephone calls, providing telephone medical advice (if it is made available), and accessing telephone interpreters. The MCO also must, at a minimum, ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls. However, the current contract does not require use of the telephone relay service, which is used by many Medi-Cal beneficiaries who are deaf or have speech disabilities. This is an essential communications tool that can be implemented at a reasonable cost to the MCOs.

Recommendations for MCO Contract (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.

6. Primary Care Providers

While members with disabilities and chronic conditions may require specialty and tertiary care services, they also require the services of a primary care provider to handle the preventive and routine assessment components of their care. Some beneficiaries express a desire to have a specialist provider who is the main source of their care. While some specialists may be willing to fill this role, others may not be due to capacity and capability concerns (e.g., inability or inexperience in providing routine primary care tests). Medi-Cal MCOs should be flexible while working with members and their families to identify non-traditional mechanisms of establishing a medical home; for example, 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. These modifications to policies will not create significant new costs for MCOs, but are important in preparation for the additional enrollment of people with disabilities and chronic conditions.

Many states that enroll large numbers of persons with disabilities and chronic conditions have specific provisions regarding primary care provider selection, medical homes, and the use of interdisciplinary teams. For example, Texas requires MCOs to provide an appropriate multidisciplinary team for people with disabilities or chronic or complex medical conditions. The team must include the PCP and any individuals or providers involved in the day-to-day care of the member. More discussion of the use of interdisciplinary care teams and the role of the care manager can be found in Section II-5, Care Management.

Recommendations for MCO Contract (NC-CR-6)

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

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

1. Facility Site Review

The current FSR used by Medi-Cal MCOs does not adequately or appropriately evaluate physical access since the current form of this tool assesses access mainly for TANF beneficiaries. CDHS should create an enhanced FSR physical access assessment tool, with assistance from qualified experts that perhaps mirrors the ADA Accessibility Checklist for Existing Facilities used by the New York State Office of Advocate for People with Disabilities. Types of site components on this checklist include: ramps (do all ramps longer than six feet have handrails on both sides?); interior accessible route (does the accessible entrance provide direct access to the main floor, lobby, or elevator?); elevators (do controls inside the cab have raised and Braille lettering?); and lifts (can the lift be used without assistance?). An enhanced tool that takes into account site characteristics can be used by MCOs to assess the accessibility of their network providers.

Recommendations for State Agencies (NC-SR-1)

The MCO's Accessibility Plan should be incorporated into the CDHS Audit and Investigation review.

2. Contractual Definitions Related to Accessibility

There are few definitions in the contract for terminology used in many of the accessibility recommendations. It is important that CDHS, the MCO, and key stakeholders have a clear understanding of the terminology used when discussing the contractual requirements related to people with disabilities and chronic conditions. There are many sources for contractual definitions of accessibility terminology; most of the definitions below were taken from the New York Medicaid managed care contract or are plain-language versions of the definitions contained in the Americans with Disabilities Act. These definitions were further refined through discussion with the stakeholder workgroups, which included representatives from the Disability Rights and Education Defense Fund (DREDF) and the Center for Disability Issues and the Health Professions (CDIHP).

Recommendations for State Agencies (NC-SR-2)

The state should use the following definitions regarding accessibility.

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

Rehabilitation Act.

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

3. *Time and Distance Standards*

The current Medi-Cal managed care contract establishes time and distance standards for PCPs (e.g., MCO shall maintain a network of PCPs which are located within 30 minutes or 10 miles of a Member's residence) and allows for exceptions when approved by CDHS, but there is no clear policy or standard for assessing network adequacy on an exception basis. Establishing uniform standards for how exceptions will be evaluated would promote consistency in access across parts of the state and across different MCOs.

Recommendations for State Agencies (NC-SR-3)

When considering MCO requests for exceptions, CDHS should consider current community standards of care and/or the California Rural Health Policy standards defining "urban," "rural," and "frontier." In addition, CDHS' assessment should include a review of the distribution of enrollees with a disability in the service area.

4. BENEFIT MANAGEMENT

A. Introduction

For people with disabilities and chronic conditions, benefit management issues largely center on: (1) the importance of maintaining functioning and quality of life when defining and determining medical necessity; (2) the criteria used to apply this definition; (3) the procedures used to evaluate the activities that determine medical necessity; and (4) the approval/denial of medical services. Ensuring access to out-of-network services when necessary and the process used to determine benefit exceptions and other types of service authorizations also are significant concerns. It is important that people reviewing treatment requests have expertise with the issues facing this population.

Currently, the benefit management responsibility largely lies within the procedures and processes established by MCOs, and executed by licensed health care professionals who use clinical judgment and guidelines to make decisions. These processes are intended to promote appropriate utilization of services and procedures within timeframes set forth by the CDHS. In comparing California's contract to other states, the current procedures and timeframes, for the most part, were in line with other states and do not necessitate modifications. The recommendations in this chapter, therefore, reflect the needs and concerns most noted by stakeholders. Values the workgroup took into consideration while developing recommendations include the following:

- For people with disabilities and chronic conditions, benefit management issues largely center around the importance of maintaining function and quality of life;
- The definition and determination of “medical necessity” and “medically necessary” should take into account treatment for conditions that are not expected to improve;
- Access to out-of-network services should guarantee access for people with disabilities and chronic conditions; and
- People with expertise in issues facing people with disabilities and chronic conditions can provide valuable input into the utilization management process.

In California, many MCOs delegate large portions of the medical services delivery and utilization management to capitated medical groups. These arrangements are reviewed by several different regulators, including CDHS for MCOs that contract with Medi-Cal. Most large MCOs have dedicated staff who conduct reviews of the delegated groups. The provisions in the current contract for oversight of delegation do not warrant major changes. However, it will be important for MCOs to maintain careful oversight of delegated entities to ensure that they continue to comply with the benefit management provisions of the contract, in particular as additional numbers of people with disabilities and chronic conditions are enrolled in managed care.

Many of the policies governing benefit management are highly regulated in California by both CDHS and DMHC, and the current contract language and state regulation appears to be adequate and working well for managed care enrollees, providers, and MCOs. Note that for benefit management and coverage decisions for Medi-Cal members, the MCO contract

with CDHS takes precedence over other MCO policies and practices. We do not recommend contract modifications in the areas of:

- Service authorization timeframes for routine authorizations, post-stabilization services, non-urgent care, pharmaceuticals, and expedited requests;
- Policies for standing referrals to specialists;
- Access to certain special services, such as HIV testing and counseling; or
- Timeframes for prior authorization, concurrent review, and retrospective reviews.

The appeals and grievances procedures and processes are established by CDHS and DMHC with timeframes within ranges observed by other states. While the appeals options and timeframes seem to work well, the state and MCOs can better communicate the various types of appeal mechanisms available to members.

A discrepancy also exists between the current Medi-Cal requirement for expedited review (within three business days) and the California MCO (Knox-Keene) requirement for expedited review (72 hours). All Medi-Cal MCOs that also are Knox-Keene licensed are bound by the stricter Knox-Keene timeframe of 72 hours. As this includes almost all Medi-Cal MCOs, CDHS should change the Medi-Cal requirement to correspond to the tighter timeframe that nearly every Medi-Cal MCO is already meeting.

B. Key Recommendations for the Medi-Cal Managed Care Contract

Summary Recommendations

Clarify criteria used to make review decisions for new technology and investigative procedures.

Include providers with specialized experience to review denials of service requests.

Modify requirement regarding authorization of out-of-plan services.

1. Criteria Used to Make Review Decisions

The criteria used today by MCOs (e.g., InterQual, Milliman and Robertson) to make review decisions are generally adequate and provide a basis upon which individuals make coverage decisions. The current contract provisions do not state that MCOs are required to use a specific set of criteria; only that they have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, consistently applied, regularly reviewed, and updated. There is opportunity to add specificity to this existing provision within the program requirements 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. This provision

should not create substantial new costs for MCOs, as most are likely to have policies already in place to review new treatments and technologies.

Some leading states have similar requirements in their Medicaid managed care contracts. For example, in Maryland, MCOs are required to provide written evidence, including treatment protocols, of the MCO's ability to provide the range of clinical and support services for special populations, such as individuals with a physical and developmental disabilities. For California MCOs, the written description of the coverage determination process should address how the MCO will provide clinical evidence supporting the coverage of interventions that meet the needs of the individual person with disabilities and/or chronic conditions, and how the MCO will incorporate appropriate medical or surgical subspecialty or expert opinion or testimony regarding coverage of interventions.

Recommendations for MCO Contract (BM-CR-1)

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

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

2. *Qualifications of Reviewers*

The current Medi-Cal contract language for reviewing treatment requests requires “qualified health professionals” to supervise review decisions and “qualified physicians” to review all denials. In situations where 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 may 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. This important provision also may create a new cost for MCOs, although the potential cost will depend on the frequency and complexity of the coverage requests that require this level of review.

MCOs should consider the “best practice” of having available practicing physicians with expertise with the member’s condition or disease on a panel to review appeals, perhaps through a statewide panel. Clinicians could participate via telephone. Challenges, however,

lie within obtaining expert opinion and the ability to respond to request within required timeframes, particularly among medical groups that are delegated responsibility for utilization management by the MCO.

Recommendations for MCO Contract (BM-CR-2)

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

3. *Authorization of Out-of-Plan Services and Unusual Specialty Services*

While MCOs are expected to contract with the full range of provider specialties within the contracted network, access to out-of-network specialists is a vital component of care for people with disabilities or chronic conditions. This is particularly important for people with multiple conditions who often rely on sub specialists who may not participate in MCO networks or delegated medical groups. There is a potential disincentive to refer members to physicians who are out of group in a delegated medical group model. MCOs, however, are able to facilitate referrals across groups. The current Medi-Cal contract requires that MCOs “arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor’s network, when determined medically necessary.” Based on other state contracts, the contractual requirement should not be limited to “seldom used or unusual” services. This is an essential change that should not require a substantial new investment by the MCOs.

Recommendations for MCO Contract (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.

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

1. *Medical Necessity and Scope of Benefits*

Medi-Cal managed care organizations are responsible for adhering to the scope of coverage outlined in the CDHS contract and the Medi-Cal definition of medical necessity. The current Medi-Cal contract defines medical necessity as covered services that are necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. CDHS applies this definition to both the fee-for-service and managed care programs.

During the workgroup discussions, concerns arose that the existing definition of medical necessity and current benefit descriptions might not be sufficient to ensure adequate access to all needed services and medical supports for people with complex health needs. The concern is even greater for people with conditions that are not expected to improve, but could nonetheless benefit from medical interventions aimed at maintaining current health status, slowing an expected decline, or preventing secondary conditions. In addition, changing the definition of medical necessity or benefit descriptions would have a significant impact on the Medi-Cal program as a whole, since these changes would apply not only to persons enrolled in managed care plans, nor solely to people with disabilities.

Workgroup members reviewed several definitions for medical necessity from sources such as the American Academy of Pediatrics and Stanford University. Some definitions noted that the interventions should 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 should reflect current bioethical (referring to ethical and moral implications of new biological discoveries and biomedical advances, as in the fields of genetic engineering and drug research) standards. Some medical necessity definitions note that interventions should not be primarily for the convenience of the patient, physician, or other health care provider and should not be more costly than an alternative service or series of services that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's condition.

Several key points are worth considering within the context of medical necessity. First, it is important to realize that the definition will impact coverage and utilization decisions, but it is not the only factor. Providers have to exercise good judgment in requesting and authorizing services. Second, maintenance of function is a key issue for people with disabilities and chronic conditions: a service may be medically necessary if it will prevent a secondary condition or help a person maintain function. The goal should be to help maintain functional ability and health status while treating underlying conditions. Third, caution must be used when including the concept of cost-effectiveness as MCOs are expected to be judicious when making utilization management decisions but also to take into account the potential longer term health consequences. Fourth, the setting in which services are taking place should be appropriate and meet the member's needs. Fifth, multiple definitions may apply to the same member (e.g., Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) requirements for children, Medicare requirements for dual eligible members). Lastly, bioethical standards exist in the hospital sector under Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements. Similarly, the use of a bioethics committee could be a best practice for MCOs to consider adopting in future years.

As the state considers options to strengthen Medi-Cal managed care, particularly for beneficiaries with disabilities or chronic conditions, it should review the medical necessity definition and benefit definitions to ensure that services provided to Medi-Cal beneficiaries assist in achieving, maintaining or restoring health and functional capabilities without discrimination to the nature of the condition and either prevent significant illness or significant disability, maintain functionality, slow the progression of a condition that would reduce independence or autonomy, or alleviate pain.

5. CARE MANAGEMENT

A. Introduction

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 that are traditionally considered to be distinct. Case management often 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. However, both case management and care coordination can use multidisciplinary team approaches and, to be effective, 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 workgroup recommended combining the concepts into a single domain that represents a continuum of coordination activities. The phrase "care management" is used here to refer to all activities and recommendations within this domain. Values the workgroup considered to be critical to all care management activities, not just for people with disabilities and chronic conditions, include:

- The member is the primary focus of care management;
- Members (and family members/caregivers, as appropriate) are active participants in the planning and evaluation of services provided to them, including self-managing their care to the extent possible and desired;
- Care management does not exist in a vacuum—it is part of the MCO's overall operations, part of the care provided by a multidisciplinary care team, and linked to the community;
- Continuity and consistency in relationships with care managers is important for members as well as their families and caregivers; and
- Members (as well as providers and caregivers) need access to information on their care plans after-hours through alternative mechanisms such as the nurse advice line.

The current Medi-Cal contract contains few requirements in the area of care management. Primary responsibility for these activities rests with the primary care provider. However, many Medi-Cal MCOs do provide care management services for members, primarily those with complex or high-cost conditions. Thus, many of the recommendations in this section are new to the Medi-Cal contract, but may not represent activities new to the MCOs. It is worth noting that many beneficiaries with disabilities and chronic illnesses receive significant services from providers and programs (e.g., behavioral health) that are carved out of the Medi-Cal managed care program. MCOs (and MCO providers) are responsible for coordinating services they provide and for working with carve-out providers to the

greatest extent possible. Mechanisms for promoting cooperation and coordination are discussed in greater detail in Section II-8, Coordination of Carve-Out Services.

To develop these new recommendations, the workgroup reviewed definitions and descriptions developed by the Case Management Society of America, the California Nurse Practice Act, the California Targeted Case Management Services program description, and National Committee for Quality Assurance (NCQA) guidelines. The group also reviewed the case management and care coordination requirements of other state Medicaid programs that enroll people with disabilities and chronic conditions, many of which provide more detailed specifications in the following areas: identifying people who may require care management assistance; components of a care plan; and the qualifications of care managers.

B. Key Recommendations for the Medi-Cal Managed Care Contract

Summary Recommendations

Create a new definition of care management.

Expand the care management program description.

Define care manager qualifications.

Describe methods for identifying and assessing people for care management.

Describe the elements in a care plan, including essential role of member in care planning.

Expand current contractual requirements for disease management.

Expand requirements regarding coordination of out-of-plan services.

1. Case Management and Care Coordination Definition

The current California contract briefly discusses case management and coordination of care, but does not provide a definition or comprehensive description of the concept or activities underlying it. Since care coordination is largely viewed as a component of case management, it is recommended that a broader definition encompassing the two concepts be used and that the phrase “care management” be used to incorporate both concepts. Before discussing specific care management recommendations for the MCO contract, members of the workgroup thought it would be beneficial to define this phrase. For example, the Arizona Medicaid managed care contract defines case management as “the process through which appropriate and cost-effective medical, medically-related social services and behavioral health services are identified, planned, obtained and monitored for individuals.” Including a common definition in the Medi-Cal managed care contract may help ensure that beneficiaries enrolled in different MCOs will have access to a similar range of care management services.

Recommendations for MCO Contract (CM-CR-1)

The MCO shall use the following definition for care management: “Care management includes identification and assessment of member needs, advocacy, facilitation and coordination of plan, carved-out and “linked” services (not covered under the Medi-Cal program but described in the contract as related social, educational, and other services needed by the member). The process should integrate the member’s strengths and needs, resulting in mutually agreed upon appropriate services that meet the medical, functional, and medically-related social needs of the member.”

2. *Care Management Program Description*

The current contract requirement identifies the primary care provider as the individual responsible for providing care management for the member, but does not include many specific requirements for a broader care management program. The PCP, an active member of the care management team, works closely with the member, care manager, specialist(s), family member/guardian, and other relevant individuals to ensure that the member receives the most comprehensive care and range of services in and outside the MCO’s network. To the greatest extent possible, MCOs should work with members and PCPs to help them self-manage their care. However, it is expected that MCOs will provide MCO-based care managers who will work in partnership with the PCP and others to ensure that the member’s overall care is coordinated and well managed.

Many other state Medicaid managed care contracts include provisions for an MCO-based care management program to support members who need care management and their PCPs. For example, Maryland requires all Medicaid MCOs to offer case management services to all enrollees in defined special needs groups and assign an MCO-based case manager (in addition to the PCP) to the enrollee when appropriate. Similarly, Minnesota’s contract requires health plans to coordinate health services for enrollees in case management, including conducting a needs assessment, assisting with prior approval, and providing care coordination assistance for social and carved-out services.

Some states require the basic elements of a care management program. Oregon has an exceptional needs care coordination provision which requires MCOs to provide exceptional needs care coordination to members who are aged, blind or disabled. Pennsylvania MCOs are required to “develop, train, and maintain a special needs unit (SNU). Members are considered to have special needs if they have key “attributes of physical, developmental, emotional or behavioral conditions.” The SNU is responsible for: ensuring persons in certain defined groups have access to PCPs, dentists, specialists and receive the information they need; arranging for and ensuring coordination between the MCO and other service systems; and acting as a liaison with various government offices, providers, public entities, and county entities.

The care management program description should address multiple aspects of care management. Because this is not a current requirement of the Medi-Cal managed care program, this could represent a significant new expense for health plans that do not currently provide MCO-level care management support for members. However, this function is essential for persons with significant medical and accommodation needs.

Recommendations for MCO Contract (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. The MCO shall maintain procedures for providing care management, with the following elements included:

- Written description of the activities and responsibilities that are part of the care management process, including procedures for monitoring the coordination of care provided, including but not limited to medically necessary services delivered in and out of the MCO's provider network;
- Annual review and evaluation of the program description with approval by the MCO's governing body;
- Process for obtaining input into the development of the MCO's care management program and annual evaluation, including input from members (families/caregivers, as appropriate) and providers;
- Standardized procedures/description/methodology for identifying members for care management, including a process for self-referral;
- Description of the qualifications of people who will act as care managers, the approach for having sufficient staff available/monitoring case loads, and the appropriate methods for using a multi-disciplinary team;
- Description of the components of a care plan, including how it is developed and reviewed;
- Process for collaborating with carve-out programs to develop and distribute a quarterly contact list;
- Process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group;
- Process for obtaining member input on satisfaction with individual care manager services;
- Information systems to support monitoring/management of care plans, the care management program, communication and information sharing among care managers and providers;
- Process to regularly update care plans based on changes in the members' medical or social status; and
- Process to obtain information on recommendations made by nurses staffing after-hours advice lines.

3. *Care Manager Qualifications*

While the current contract does not specify that care managers must be licensed health care professionals, MCOs almost always use registered nurses to perform care management activities due to the clinical and sometimes complex nature of members' medical needs. Advocates for people with disabilities and chronic conditions have underscored the importance of having staff who are not just licensed and qualified, but also have experience in working with and serving people in this population. Because of the limited availability of individuals who are licensed or certified and experienced, some health plans noted that it may be difficult to guarantee that they can hire clinical staff who meet these requirements. Further, while availability of qualified, experienced, licensed professionals is limited, MCOs should continue to recruit staff with experience/expertise with "preferred" qualifications. In addition, teams can be used to provide the necessary combination of clinical expertise and disability experience. MCOs should be responsible for delivering training and providing necessary information so that staff may perform their responsibilities in a sensitive, competent manner.

Most states have specific requirements for persons who will serve as care managers. While many Medi-Cal MCOs or their delegated medical groups current provide care management services, if a Medi-Cal MCO does not currently provide comprehensive care management support for members, this would create a new cost to the plan. However, having qualified staff is a key aspect of a successful care management function and should be a priority.

Recommendations for MCO Contract (CM-CR-3)

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

4. *Identification and Assessment of People for Care Management*

While all managed care enrollees select (or are assigned, if they do not select) 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 only require periodic or one-time assistance with a catastrophic condition or temporary situation. California currently requires all new members to receive an Initial Health Assessment from their primary care providers during their first visit, which must be scheduled within 120 days of enrollment. This assessment provides the PCP with

information to determine what type (if any) of care coordination the member may require. However, there is no provision in the current Medi-Cal contract for the PCP to share this information with the MCO or for the MCO to conduct its own screening.

Identification of members who may require care management can be accomplished through a variety of mechanisms. Ideally, a screening is conducted upon enrollment, as is the case for states like New York. In Arizona, the case manager is required to make initial contact with the member within seven working days of enrollment and initial on-site contact with the member within 12 working days of enrollment. He or she must ensure initiation of necessary services and placement within an appropriate setting within 30 days of enrollment.

MCOs could develop screening tools using existing managed care tools, with some modifications for the Medi-Cal enrolled population. For example, in Medicare each health plan designated as a Medicare Advantage Organization (MAO) is required to have a chronic care improvement program that includes methods for identifying enrollees with multiple chronic conditions and mechanisms for monitoring enrollees participating in the program. Most MAOs conduct screenings upon enrollment and use a tool tailored to survey the needs of those 65 and older, e.g., PRA Plus, a screening tool widely used by MAOs and approved by CMS. The Mini Mental State Exam (MMSE) also could be used to screen for certain types of conditions that might indicate a need for care management.

Many Medi-Cal MCOs conduct identification and assessment both at enrollment and on an ongoing basis, (e.g., welcome call and risk assessments) so that high risk or complicated conditions can be identified and managed promptly and appropriately. Although many of the identification and assessment methods described here are already in practice in many California MCOs (partly because many are currently required for accreditation by NCQA, the primary managed care accreditation organization), it is important to clearly it in the contract. This will help ensure that Medi-Cal MCOs that operate through a variety of managed care models all provide the same level of access to enrollees.

Recommendations for MCO Contract (CM-CR-4)

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

- Member, family member, caregiver/guardian's request;
- Referral from a specialist or PCP, or other provider (e.g., regional center, CCS provider);
- Referral from internal MCO staff (e.g., member services, complaints and grievances);
- Presence of an external care manager;
- Regular reviews of utilization and claims/encounter data, ER visits, lab, pharmacy scripts, DME, transplant request, and hospitalizations;

- Routine mining of claims/encounter data with algorithms established by the MCO;
- Triggers identified as being risk factors during initial screening of new members or during a later assessment (e.g., chronic homelessness/living arrangements, receipt of in-home supportive services, safety concerns, presence of a caregiver, enrollment in a county behavioral health program, enrollment in a community-based long-term care or contact with that system, regular visits to multiple specialists, presence of a cognitive impairment/certain conditions, missed appointment or referrals);
- Participation in multiple disease management programs (or identification or multiple conditions that could qualify for disease management); and
- Auto-assignment (of people in certain aid codes) to a PCP, which may indicate a concern with continuity of care.

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

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

5. *Care Plan Components*

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. The current contract does not state that MCOs are required to develop care plans for members, nor does it require specific elements. It is important to have a contract requirement (instead of relying on MCOs to continue current practice) to maintain accountability at all levels of the managed care program. The recommended care plan components are consistent with NCQA guidelines and are likely already performed by accredited MCOs, which include many of the current Medi-Cal MCOs. Therefore, while the care plan is an essential activity, it is not expected to require a substantial new investment for most Medi-Cal MCOs.

Recommendations for MCO Contract (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. The care plan shall be developed by the care manager in collaboration with the PCP, treating

specialists, interdisciplinary team (if indicated), and member (and his/her representative, if desired) that takes into account the following elements, as appropriate for each member:

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

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

6. *Disease Management*

Language in the current MCO contract states that disease management (DM) programs must be initiated and maintained. The MCO determines the program's targeted disease conditions and implements a system to identify and encourage members to participate. Based on a definition used by the Disease Management Association of America, disease management is "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." Other groups such as the Utilization Review Accreditation Commission (URAC) have adopted this definition as well or use similar definitions.

Using the definition stated above, recommendations can be made for identifying targeted conditions for MCO DM programs. Medi-Cal MCOs currently identify conditions for DM programs by referring to findings documented in the Quality Improvement annual report or Group Needs Assessment. Some Medi-Cal MCOs with established DM programs use member incentives in order to encourage use of recommended services and behaviors (e.g., a Wal-Mart gift certificate for completing an asthma education module).

Every effort must be made to customize the program to include members who have multiple conditions. In Texas, MCOs are required to develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at-risk for or diagnosed with chronic conditions. The MCO is then charged with ensuring that all members identified for DM are enrolled into a DM program with the opportunity to opt out of these services within 30 days. Program elements contractually required include: self-management education; provider education; evidence-based minimum standards of care (to the extent these are available); physician-directed or physician-supervised care; implementation of interventions that address continuum of care; mechanisms to modify or change interventions that are not proven effective; and mechanisms to monitor the impact of the DM program over time, including both the clinical and financial impact.

Medi-Cal MCOs can, over the longer term, assess the needs of members to determine which DM initiatives are appropriate, where patterns of care exist, and whether certain conditions are more likely to have co-morbidities. This is an important contract requirement and because the plans are likely to have disease management programs that incorporate these components, it is not expected to create a new cost.

Recommendations for MCO Contract (CM-CR-6)

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

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

7. *Coordination of Out-of-Plan Services*

Current contract provisions state that MCOs are required to implement procedures to identify individuals who may need/are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery. For people with disabilities and chronic conditions, however, the current language does not provide sufficient assurance that coordination with out-of-plan services occurs at the necessary level. (For further discussion on this topic see Section II-8, Coordination of Carve-Out Services.)

Recommendations for MCO Contract (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.

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

1. *Develop an Ongoing Working Group to Encourage Adoption of Best Practices*

Many Medicaid managed care programs in other states have piloted innovative care management models and programs. In addition, some Medi-Cal MCOs and other

California managed care programs, such as the On Lok Program of All-Inclusive Care for the Elderly, have developed case management and care coordination programs that go beyond the current Medi-Cal contract requirements. Some payers are working with providers to implement electronic medical record systems; these systems would support the care management process by giving all members of the interdisciplinary care team and MCO access to current information on a member's care. Many of these emerging practices have been developed in smaller programs in California and in other states.

CDHS should work with the Medi-Cal MCOs to explore the adoption of some of these industry leading edge practices, perhaps by developing an ongoing working group that evaluates emerging best practices in care management. The workgroup could evaluate the merits of such best practices and discuss how to "scale" them in a program as large as Medi-Cal.

Recommendations for State Agencies (CM-SR-1)

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

6. QUALITY IMPROVEMENT

A. Introduction

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.²⁰ As such, 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). Medi-Cal health plans have underscored that improving health care quality for members not only improves member health, but also leads to reduced cost and utilization—it is simply good business to create an effective quality improvement system. However, 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.²¹ As the number of conditions a beneficiary has increases, so does the complexity of his or her health care needs. Health plans may have to modify their existing quality improvement processes to better meet the needs of people with disabilities and multiple conditions.

Medi-Cal's current contract addresses multiple components of an MCO's quality improvement program, including forming a QI committee; developing a written description of quality improvement activities; and conducting quality improvement projects. However, quality improvement is an area of the Medi-Cal contract where most MCOs currently exceed the contract requirements because many have adopted industry practices or standards developed by national accreditation organizations that go beyond the requirements of the Medi-Cal program. The QI workgroup supported many recommendations that facilitate an MCO's ability to use member data to better target QI activities (e.g., development of initial health assessment; transfer of historical member-level data from the FFS program to MCOs, and conducting quality improvement project specific to people with disabilities and chronic conditions). These recommendations would provide MCOs with information to better implement leading QI practices for Medi-Cal enrollees.

The recommendations listed in this section reflect the need to identify data that may point to gaps in care and service as well as share existing information about clinical conditions most likely to affect people with disabilities and chronic conditions. The recommended contract changes outline different methods for gathering or mining the data that MCOs have through strategies such as stratifying data and conducting quality improvement projects specific to people with disabilities and chronic conditions. In addition, the recommendations reflect approaches successfully used by states such as New Jersey and Texas to identify and share different types of data about members with disabilities and chronic conditions.

The recommendations listed in this section reflect the following workgroup values for quality improvement:

- Tailor existing quality improvement requirements to create opportunities to gather information about gaps in care and best practices for people with disabilities and chronic conditions;
- Conduct coordinated quality improvement activities across MCOs; and
- Commit to quality improvement across the whole health care system (including carve-out entities).

B. Key Recommendations for the Medi-Cal Managed Care Contract

Summary Recommendations

Improve mechanisms for identifying members with disabilities and multiple chronic conditions.

Collect and stratify utilization indicators.

Coordinate quality improvement efforts.

Identify and share evidence-based guidelines.

Engage providers in the quality improvement process.

1. Identifying Members with Disabilities and Multiple Chronic Conditions

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 also use inpatient, outpatient, pharmacy data and diagnostic/procedure codes to identify populations that are not receiving appropriate care.

Quality improvement activities for members with disabilities and multiple chronic conditions should begin by identifying them as a subset of the MCO's overall membership. This is because some areas of concern that may occur frequently among this population may be relatively rare if looked at across all MCO enrollees, most of whom are healthy. Once the data on members with disabilities and multiple chronic conditions is identified, it can be analyzed to identify opportunities for clinical or service improvement within this particular subset of members. For example, the MCO could cluster or group members with similar conditions in order to identify an even smaller population with similar needs (e.g., members with mobility impairments and diabetes). This will enable MCOs to design and implement quality improvement activities/interventions based on the particular needs of a

targeted group of members (e.g., provide care management, decrease ER rates, and send health education information). By stratifying the identified population within or across chronic conditions, MCOs may also be able to use outreach and intervention resources more strategically.

Although population stratification is a quality improvement technique used by many health plans in other states, it is not a current Medi-Cal MCO requirement. Adding a requirement for MCOs to identify and stratify their members with disabilities and multiple chronic conditions may result in a moderate amount of upfront costs, but will be essential in enabling health plans to strategically target their quality improvement activities.

CDHS should provide MCOs with historical FFS clinical data on members prior to or during the first year of implementation. (The COHS plans that currently enroll SSI-eligible individuals already have baseline encounter data for this population, but the Two-Plan Models and the Geographic Managed Care plans will require historical claims data.) In future years, MCOs will add to these historical clinical data and have an increasingly robust clinical profile of their members to enable them to more accurately identify and stratify their membership. Note that, while this is an important recommendation, it should be considered even more necessary if MCO recommendation CC-SR-3 (CDHS provides MCOs with historical FFS data on its new members) is not implemented.

Recommendations for MCO Contract (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.

2. *Stratify Utilization Indicators*

Medi-Cal plans are required to submit encounter data to CDHS to produce Use of Service Reports. These reports allow for comparisons of utilization rates among MCOs. Utilization data in the reports include: outpatient visits, emergency room visits, total hospitalizations, pharmacy costs, and laboratory tests.²² These data are essential to collect because they offer “rough” measures of the ability to access services. Although no national benchmarks exist for “proper utilization performance,” some utilization measures can serve as useful indicators of positive medical outcomes and 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.

Although the current Medi-Cal language does not require MCOs to stratify utilization measures by eligibility category (e.g., SSI and TANF) or other subcategories (e.g., age, race), stratified utilization data will allow CDHS to identify differences in utilization across various subsets of its members. Further, MCOs can use these data to identify trends or red flags of over/under utilization. For example, by separately analyzing its health plan data by eligibility category, Oregon was able to find access problems to durable medical

equipment and that people with disabilities were not receiving the same level of preventive care services, such as mammograms and Pap smears, as the TANF population. The cost of implementing this recommendation could be low to moderate depending on the health plan's data and technological capabilities.

Recommendations for MCO Contract (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 CDHS, 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.*

3. Collecting Additional Utilization Indicators

Due to the potential changes in Medi-Cal MCO membership, CDHS should consider collecting data on a few additional utilization indicators. Durable medical equipment use and hospitalizations for ambulatory sensitive conditions (also referred to in this document as “preventable hospitalizations”) are two areas of particular relevance for people with disabilities and multiple chronic conditions. People with disabilities and chronic conditions tend to use more medical equipment and have higher hospitalization rates than healthier members. Although analyzing DME data may be difficult to do (due to numerous DME codes), MCOs could start by collecting and trending high level DME utilization data. In the first years following a large influx of members with disabilities and chronic conditions, MCOs should collect data on DME claims paid and the number of repairs of DME. By trending this type of DME data, Axis Health Plan (Minnesota) identified “red flags” in their equipment repair rates for members with disabilities. Based on the red flags, health plans also can drill down in their data and identify members with faulty equipment and discuss potential resolutions. In addition to collecting DME utilization indicators, CDHS also can capture member satisfaction with access to and timeliness of repair of DME through the consumer satisfaction survey recommended in Section II-7, Performance Measurement.

CDHS should consider using the Agency for Healthcare Research and Quality's Ambulatory Sensitive Conditions list (see Appendix D) as a starting point for identifying which preventable hospitalizations data to collect. The conditions listed (e.g., urinary tract infections, chronic obstructive pulmonary disease, bacterial pneumonia) are common in people with disabilities and chronic conditions and represent conditions that could be preventable with effective outpatient care. Collecting these type of utilization data may require a moderate amount of health plan resources.

Recommendations for MCO Contract (QI-CR-3)

The MCO shall collect utilization data in the following areas:

- Durable medical equipment; and
- Preventable hospitalizations.

4. *Coordinating Quality Improvement Efforts*

Currently, MCOs are required to conduct four Quality Improvement Projects (QIPs). One of these must be a statewide collaborative project. Rather than increasing the number of required quality improvement projects, it may be more effective to use the existing requirement as an opportunity to learn more about people in Medi-Cal with disabilities and chronic conditions and improve the quality of their care. The State of Wisconsin requires Medicaid MCOs to develop performance improvement projects that address specific clinical issues with high prevalence among its membership. A statewide collaborative project can provide the state with an opportunity to share best practices across MCOs, particularly when expanding to new populations.

As Medi-Cal MCOs begin to 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). After the first few years of enrollment, MCOs should then focus on developing quality improvement projects that seek to improve clinical outcomes. Since MCO participation in a statewide collaborative project is a current Medi-Cal contract requirement, this activity should not require additional resources.

Recommendations for MCO Contract (QI-CR-4)

The MCOs shall conduct a QIP on an issue related to people with disabilities and chronic conditions. This project will be counted as the next statewide QIP and will require MCOs to collaborate and share data. For year 1, MCOs should focus on issues such as access and consumer satisfaction. In years 2-3, as MCOs begin to learn more about their new members, the quality improvement projects shall focus on improving clinical outcomes.

5. *Identifying and Sharing Evidence-Based Guidelines Among MCOs*

Many workgroup and Advisory Group participants felt strongly that providers engaging in quality improvement activities need to reference established clinical protocols or evidenced-based guidelines whenever possible. However, while there are many disease-specific guidelines, most 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 co-morbidities. As Medi-Cal begins to increase the number of members

enrolled in managed care with disabilities and chronic conditions it will be ideal for MCOs to enhance their existing mechanisms for sharing evidenced-based guidelines (where they exist) with providers. Where few evidence-based guidelines exist, MCOs need to support providers in accessing best practices and other types of clinical decision support tools that they can use to identify appropriate treatment protocols. Since many MCOs already use newsletters and websites to share this type of information with members and providers, enhancing the current information dissemination processes could be done at a low cost.

Recommendations for MCO Contract (QI-CR-5)

The MCO shall develop and implement a process for disseminating information through multiple strategies both passive and active (e.g., passive: posting information on websites, or active: academic detailing²³) to its providers regarding best practices, evidenced-based standards, and guidelines (for those that exist) for serving people with disabilities and chronic conditions. The information should be disseminated on an ongoing basis. The MCO shall outline a plan to train and educate providers on ways to implement the guidelines and standards of care.

6. *Engaging Providers in Quality Improvement Processes*

In addition to creating avenues for direct consumer input into health plan processes (see recommendation in Section II-1, Cross-Cutting Issues regarding consumer participation in the health plans' decision-making process and advisory groups), New Jersey also created similar opportunities for providers who have experience in treating members with disabilities and chronic conditions. The workgroup felt that it was important for both consumers and the physicians who treat them to be included in the quality improvement process. However, because of the highly technical nature of the MCOs Quality Improvement Committees, they agreed that providers may be in a better position to make contributions in this arena. Most health plans already have QI committees in place, so it is anticipated that modifying the composition of the committees should not be costly.

Recommendations for MCO Contract (QI-CR-6)

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

7. *Quality Improvement System Description*

The Medi-Cal contract requires each MCO to implement and maintain a written description of its quality improvement systems. To comply, the MCO describes various aspects of its quality improvement processes such as descriptions of the quality of clinical services, what mechanisms are used to review access to and availability of care, as well as

other methods used to target quality improvement activities. While this written description provides helpful information for MCOs, no requirements exist to have quality improvement activities specific for people with disabilities and chronic conditions. The recommendation listed below slightly alters the current contract language to require a separate description of activities addressing members with disabilities and chronic conditions. In this way, the targeted activities and overall quality improvement plan for this population can be easily identified. The workgroup felt this was an important recommendation and saw it as a low cost way to ensure that clinical areas relevant to people with disabilities and chronic conditions were addressed in quality improvement activities.

Recommendations for MCO Contract (QI-CR-7)

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

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

1. *Identifying and Stratifying the Population by Disabilities and Chronic Conditions*

This recommendation reflects the CDHS activities that could support the MCO recommendation requiring MCOs to stratify their member data.

Recommendations for State Agencies (QI-SR-1)

For year 1 of enrollment, CDHS should provide each MCO with stratified member data based on the most prevalent chronic conditions and disabilities.

2. *Stratifying Utilization Indicators*

This recommendation is the companion CDHS component to the MCO recommendation requiring MCOs to stratify utilization measures by eligibility category. This recommendation suggests that CDHS provide MCOs with stratified utilization data that is aggregated across participating MCOs. These types of data are essential for MCOs to use as they evaluate their own utilization rates in comparison to other plans and a statewide normative benchmark. Sharing these data can help MCOs assess reductions or increases in utilization during the first year after transitioning into managed care. To facilitate an exchange of information and understanding of the data, CDHS should, on an annual basis, review the resulting data with MCOs.

CDHS should consider using a stratification methodology that will ensure statistically significant results. Since Medi-Cal MCOs differ in case-mix, stratification of data may require risk-adjustment to produce results that can be used for comparison purposes. Maryland performed diagnostic-based risk-adjustment for each of its MCOs based on the state's set of specially developed measures for people with chronic conditions.

Recommendations for State Agencies (QI-SR-2)

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

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

3. *Coordinating Quality Improvement Projects Across MCOs and State Agencies Providing Carved-Out Services*

This recommendation reflects the CDHS activities needed to support the recommendation that requires MCOs to conduct quality improvement projects on issues relevant to people with disabilities and chronic conditions as their next statewide QIP.

Recommendations for State Agencies (QI-SR-3)

CDHS should select, as its next statewide collaborative quality improvement project, an issue related to people with disabilities and chronic conditions. For the first year, the MCOs should focus on issues such as access and consumer satisfaction. In years 2-3, as the MCOs begin to learn more about their new members, their quality improvement projects should focus on improving clinical outcomes.

Coordinating quality improvement projects across MCOs should be seen as a key step toward improving health care quality. The fragmented Medi-Cal system, with all of its carve-outs, presents a prime opportunity for coordinating quality improvement efforts. Ideally, creating ways for the MCOs and the carved-out entities to collaborate may break down silos and generate synergistic quality improvement programs. The workgroup noted that creating a Quality Improvement Project that required participation from both the MCOs and the carve-out agencies (e.g., Department of Mental Health, Department of Developmental Services, Office of Alcohol and Drug Programs) would serve as an opportunity to improve the care delivered to members. Since Medi-Cal does not have authority over all the entities that provide carve-out services, the authority to facilitate this project would have come from CDHS or the legislature. The workgroup strongly supported bringing in appropriate technical expertise to assist in developing such a project, as this was considered crucial for the successful implementation of this recommendation.

Recommendations for State Agencies (QI-SR-4)

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

4. *Identifying and Sharing Best-Practices and Evidence-Based Guidelines*

As mentioned in the MCO recommendation requiring MCOs to establish a process for disseminating best practices and evidence-based guidelines, there is a dearth of evidence-based guidelines for treating people with complex clinical needs and disabilities. Realizing that providers rely on standards of practice to guide their intervention protocols, ideally CDHS should take an active role in identifying evidence-based guidelines or best practices (when there are no evidence-based guidelines) most appropriate for treating people with disabilities and chronic conditions. Rather than forming a new committee, the existing CDHS Quality Improvement Committee should be charged with collecting and sharing best practice information on members with disabilities and chronic conditions.

Recommendations for State Agencies (QI-SR-5)

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

7. PERFORMANCE MEASUREMENT

A. Introduction

The adage “you can’t manage what you can’t measure” is particularly relevant in considering an expansion of the Medi-Cal program to include people with disabilities and chronic conditions. The measures Medi-Cal currently requires MCOs to collect do not measure a full range of issues or identify issues that are specific to the health care needs of adults with disabilities and chronic conditions.

The Medi-Cal managed care contract, like managed care contracts in many other states, requires MCOs to provide results for the NCQA-developed HEDIS measures. Table 2 lists CDHS’ External Accountability Set (EAS) measures, a subset of HEDIS measures that Medi-Cal requires MCOs to collect. Medi-Cal only requires plans to report 12 of the total number of HEDIS measures, which is a small number of measures compared with other states (e.g., Maryland, New York, Rhode Island). In addition to the EAS, MCOs also are required to conduct a consumer satisfaction survey based on the Agency for Healthcare Research and Quality’s CAHPS health plan survey and provide utilization data for CDHS’ Use of Service Reports.

The performance measurement reporting requirements are closely connected to the quality improvement requirements. Measuring and monitoring health plan performance allows CDHS to identify areas that need improvement and target quality improvement efforts accordingly. As a result, the measurement strategies CDHS implements are vitally important to quality improvement efforts.

Table 2. Medi-Cal’s Current Performance Measurement Requirements

External Accountability Set Measures	
Well-child visits < 15 months Source: HEDIS	Postpartum care Source: HEDIS
Well-child visits 3-6 years old Source: HEDIS	Chlamydia screening Source: HEDIS
Adolescent well-care visits Source: HEDIS	Appropriate use of medications for people with asthma Source: HEDIS
Childhood immunization status combination 1 Source: HEDIS	Breast cancer screening Source: HEDIS
Childhood immunization status combination 2 Source: HEDIS	Cervical cancer screening Source: HEDIS
Timeliness of prenatal care Source: HEDIS	Retinal eye exams *only required for COHS Source: HEDIS
Childhood blood lead screening Source: CDHS-developed measure	Overuse of asthma rescue medicine Source: CDHS-related measure

Consumer Satisfaction Measures (CAHPS)	
Getting needed care	Courtesy and helpfulness of office staff
Getting needed care without long waits	Health plan customer service
How well doctors communicate	

The existing EAS measures, which target children’s issues and few chronic conditions, reflect issues common to the majority of Medi-Cal’s current membership (women and children). This limitation is not especially significant when the Medicaid program is focused largely on populations that are not chronically ill or disabled (e.g., TANF). However, as Medi-Cal begins to increase the number of SSI-eligible beneficiaries in managed care plans, the limitations of measures such as HEDIS becomes much more of an issue.

Medi-Cal should enhance its current measurement requirements by selecting measures for the conditions that affect a larger proportion of these new MCO enrollees. Unfortunately, no national measurement sets (comparable to HEDIS) used by Medicaid managed care health plans address a wide range of health care issues relevant to people with disabilities and chronic conditions. Organizations such as the American Medical Directors Association and the Veterans Administration have been successful in developing a few measures that address issues relevant to people with disabilities and chronic conditions. However, the lack of more complete national measurement sets may be attributed to limited information about evidence-based practices for this population, the prevalence of their conditions relative to other conditions, and commercial purchaser priorities (which tend to drive national measurement sets). In addition, many of the randomized trials that have led to disease-specific guidelines have excluded 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 and the corresponding performance measures in many cases are scant or simply do not exist.

While most states have not developed performance measures specific to people with disabilities or chronic conditions, some have taken steps to improve how to assess whether people with disabilities and chronic conditions are receiving appropriate services. The enhanced quality improvement requirements, in conjunction with the recommendations in this section, should equip both CDHS and MCOs with a greater capacity to improve the quality of care for these beneficiaries. These strategies cannot all be implemented in the first year of expansion, but can be phased in over time.

Medi-Cal, due to the potential volume of people with disabilities and chronic conditions to be enrolled, is in a position to lead the field in pilot testing the best practices outlined in this section. Other methods for collecting information on health plan performance that are addressed in this section include requiring MCOs to stratify data by eligibility category and developing specialized consumer satisfaction surveys.

The recommendations in this section reflect the following workgroup values:

- Consider what information MCOs currently collect about their members through the existing measurement requirements;
- Identify measures that provide information that is different from the data currently collected;
- Understand the impact and ability to collect or develop additional measures (both at the health plan and CDHS-level); and
- Create opportunities for Medi-Cal to lead the field in pilot testing certain measures.

This section addresses Medi-Cal’s health plan performance measurement requirements. These measures focus on clinical and consumer satisfaction issues, and are separate from methods used to monitor health plan contract compliance, grievances and appeals, site access audits, etc. The recommendations for monitoring contract compliance will be developed by the consultant team over the next several months.

B. Key Recommendations for the Medi-Cal Managed Care Contract

Summary Recommendations

Stratify HEDIS measures collected by Medi-Cal.

Add additional measures to Medi-Cal’s External Accountability Set.

Develop consumer satisfaction survey.

Link incentives to MCO performance.

1. *Stratify HEDIS Measures Collected by Medi-Cal*

Stratifying the existing HEDIS measures that the MCOs currently collect is a method that can be used to better assess access to preventive and chronic care services for people with disabilities and chronic conditions. This strategy will yield essential information that will help MCOs identify gaps in access to care. Many health plans across the country use stratification of data as a key step to identifying areas needing quality improvement. Depending on a health plan’s technical capabilities, there may be some additional upfront costs associated with implementing this recommendation.

Recommendations for MCO Contract (PM-CR-1)

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

- Appropriate use of medication for people with asthma;
- Breast cancer screenings;

- Cervical cancer screening; and
- Retinal eye exam for people with diabetes (currently only required of COHS plans).

2. *Add Additional HEDIS Measures to Medi-Cal's External Accountability Set*

Currently, only four of the 12 EAS measures are relevant to adults with disabilities and/or chronic conditions: asthma medication, preventive screenings for breast and cervical cancer, and retinal eye exam for people with diabetes. This recommendation proposes to adopt additional HEDIS measures relevant to people with chronic conditions and disabilities.

The workgroup participants representing health plans were most comfortable using HEDIS measures because HEDIS is a national measurement set that uses evidence-based measures. This recommendation includes additional chronic conditions and clinical issues relevant in the HEDIS measurement set that are not currently part of the EAS. The measures recommended were selected because they represent clinical issues common for people with disabilities and chronic conditions (e.g., high blood pressure, diabetes, cardiovascular conditions). Requiring MCOS to collect additional HEDIS measures will be essential to providing both the state and the health plans with a more relevant information about its members with disabilities.

Many states, such as New York, Michigan, and Maryland (which have all expanded their Medicaid managed care programs to include SSI-eligible beneficiaries), collect a larger set of HEDIS measures than the Medi-Cal program. For example, in addition to the measures Medi-Cal collects, New York requires its MCOs to report on the following HEDIS measures: colorectal cancer screening, comprehensive diabetes, cholesterol management after acute cardiovascular event, and beta blocker use after a heart attack. Maryland also collects the appropriate medication management for adults diagnosed with depression measure. Several Medi-Cal health plans, including Partnership Health Plan, Molina, and Inland Empire Health Plan (IEHP), already are collecting several measures in addition to the required Medi-Cal EAS. These measures include comprehensive diabetes measures, controlling high blood pressure, and cholesterol management after an acute cardiovascular event. At the time of this report, Medi-Cal was in the process of deciding whether to add the comprehensive diabetes measure as a requirement for all MCOs.

The feedback received from CDHS indicates that the current contract with the EQRO, the organization that validates the EAS measures, may have to change if the number of measures it currently collects is increased. An alternative to implementing this recommendation is for CDHS to rotate the HEDIS measures on a yearly basis. This would allow Medi-Cal to maintain the same number of measures collected, but at the same time expand the range of areas covered by the measures. The costs associated with collecting additional HEDIS measures could range from low to moderate cost depending on the number and type of measures chosen.

Recommendations for MCO Contract (PM-CR-2)

MCOs shall collect the following HEDIS measures²⁴ in addition to its EAS reporting requirements:

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

C. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

1. Identifying Non-HEDIS Measures to Add to Medi-Cal's Measurement Set

The previous recommendation to add “more relevant” HEDIS measures to Medi-Cal’s EAS is a first step toward equipping California with a measurement set that can better track MCO performance for people with disabilities and chronic conditions. However, HEDIS measures and other national measurement sets do not fully address issues such as co-occurring conditions, mobility impairment, and secondary complications that are vitally important to serving people with disabilities and chronic conditions.

Adding non-nationally-tested measures was an area of divergent opinions in the workgroup. Many MCOs workgroup members were concerned that the plans would be held accountable for performing at a certain level (above an established Medi-Cal minimum performance level) on measures where national standards may not exist or about which MCOs are unfamiliar. As a result, many health plan participants were hesitant to add measures to the required set. In contrast, consumer advocates felt that unless CDHS made an effort to incorporate additional non-HEDIS measures, CDHS would be enrolling people with disabilities and chronic conditions into managed care with few adequate or appropriate methods for measuring health plan performance and health outcomes.

No one recommended set of measures exists that CDHS can use to address all the clinical issues relevant for people with disabilities and chronic conditions. However, CDHS should take advantage of the opportunity to select from the measures used by other states and MCOs that best fit the diseases and chronic conditions most prevalent in Medi-Cal. Some Medicaid managed care programs, such as those in Maryland and Wisconsin, have developed a small set of non-HEDIS measures focused on their most prevalent disease and

chronic conditions (e.g., asthma, diabetes, HIV/AIDS). Maryland's measures are different than HEDIS measures in that they look at a combination of areas (e.g., avoidable inpatient admissions, ambulatory care visits, and specific clinical tests for each condition).²⁵ These two states were able to develop and collect these measures because of the accuracy and completeness of their data. In addition to collecting HEDIS measures, Pennsylvania also collects measures such as cervical cancer screenings for HIV positive women, dental visits for people with developmental disabilities, and appropriate pharmaceutical treatment for people newly diagnosed with depression. Highly specialized programs that coordinate care and provide social and medical services for people with disabilities and chronic conditions such as AXIS Health Care (Minnesota) and Community Living Alliance (Wisconsin) have begun to develop and test performance measures specific to people with disabilities and/or chronic conditions. In large part, these programs are able to test these measures due to their small, "niche" size. Aside from the challenge of taking these measurement approaches to scale, MCOs are further challenged by the reliance on long-term care institutions or hospitals to accurately code incidences of avoidable complications such as skin ulcers, bowel impaction, and urinary tract infections.

The workgroup identified a list of priority areas for CDHS to use to focus its work on identifying additional performance measures. This priority list was modified by the planning team to include additional clinical priority areas that are relevant to the health needs of people with disabilities and chronic conditions. Dental health was added as a clinical priority area because health care research shows that dental problems are exacerbated by other conditions (e.g., diabetes, HIV/AIDS, pharmaceutical treatment for seizures). Although dental services are carved out of the MCO contract in some counties, the state should require dental contractors to provide this information to the MCO.

It is important that CDHS look beyond existing measurement sets, yet keeps in mind that any new measure that is not nationally used should be slowly rolled out before it is made a mandatory Medi-Cal requirement. To lessen the fear of MCOs being penalized for low performance on non-HEDIS measures, CDHS should consider using the first year of measurement testing as a "learning experience" and not include any of these measures in its assessment of health plan performance until there is stakeholder consensus that the measure is appropriate to include. In the case where there is little scientific evidence for a particular measure, CDHS should use the quality improvement activities recommended in the Section II-6, Quality Improvement, as additional ways to collect baseline information. By employing this method, CDHS can point to measures that may not be evidence-based or nationally tested but serve as a starting point for measuring health plan performance and health outcomes for this population. Given the significant potential volume of new SSI-eligible members, CDHS has an opportunity and responsibility to be a testing ground for both California and the nation.

Recommendations for State Agencies (PM-SR-1)

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

Clinical Priority Areas

- Screenings (e.g., depression and osteoporosis);
- Secondary conditions/complications in disabled people (e.g. urinary tract infections, skin ulcers/decubiti, osteoporosis, etc.);
- Obesity;
- Depression;
- Dental (care and prevention);
- Pain management;
- Identification of adequate treatment for high risk cases;
- Prevention and care of acute and chronic conditions;
- Care management and continuity of care; and
- Ambulatory Sensitive Conditions (AHRQ).

Non-Clinical Priority Areas

- Emergency Department use; and
- Access to and availability of services.

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

2. Developing a Consumer Satisfaction Survey for People with Disabilities and Chronic Conditions

Like most states, California uses the Agency for Healthcare Research and Quality's CAHPS survey to assess consumer satisfaction within contracted MCOs. Although this survey is used across the country, many of the questions in the survey do not adequately identify or address health plan satisfaction issues specifically relevant to people with disabilities and chronic conditions. In order to address some of the differences in needs and issues, AHRQ also has developed several supplemental modules to the CAHPS survey that get closer to identifying the needs of people with disabilities and chronic conditions. For example, AHRQ has developed a survey for people with mobility impairments and another to assess satisfaction with behavioral health services. Although these surveys are still in the process of being pilot tested, they may be applicable for California's future use. In addition, AHRQ has a subset of supplemental questions for adults in Medicaid managed care that includes questions about problems with language, specialist referrals, and behavioral health care.²⁶

Seeing the potential to develop enhanced survey tools that more effectively capture health plan satisfaction issues relevant to people with disabilities and chronic conditions, a few California MCOs such as CalOptima and Inland Empire Health Plan (IEHP) have developed their own CAHPS-like surveys for these populations. An enhanced survey will be an essential tool in helping MCOs learn more about their members disabilities and chronic conditions, as member satisfaction is closely tied to access to health care services.

Recommendations for State Agencies (PM-SR-2)

In year 1, CDHS, working with key stakeholders, should develop a standardized statewide consumer satisfaction survey tailored to identify issues important to people with disabilities and chronic conditions. The survey questions should build off the existing CAHPS surveys, but also address additional areas more specific to the needs of people with disabilities and chronic conditions (e.g., care coordination and DME)

Guidelines for administering the survey

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

Survey should be sent annually.

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

Stakeholder group

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

Areas of emphasis for survey

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

Guidelines for survey questions

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

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

3. *Linking Incentives to MCO Performance*

Incentives have shown to be an effective way to encourage excellence in care and should be used as a tool to improve health care quality. For example, performance incentives can be used to encourage MCOs to organize care across a member's multiple chronic conditions, risk factors, and services utilized. CDHS has already developed a quality incentive project that rewards high performing MCOs by assigning them higher proportions of Medi-Cal beneficiaries who do not choose a health plan (i.e., auto-assignment). In addition to auto-assignment, CDHS could pursue additional ways to reward MCO performance. The workgroup saw the idea of linking financial incentives to health plan performance as an ideal recommendation. Due to the perceived inadequacy of current health plan payment rates, the workgroup expressed a level of hesitation in regards to implementing a financial incentive program. If the CDHS decides to implement a financial incentive strategy, any financial incentives should be paid in addition to adequate capitation rates. The idea of tying financial incentives to performance also was discussed in

the context of encouraging coordination of services between MCOs and the carved-out entities (e.g., tying reimbursement to performance of MCOs and carve-out agencies).

CDHS also should consider risk-adjusting performance measures to reduce the effect of case-mix differences among MCOs. Risk-adjusting performance measures can level the playing field by adjusting outcome data for MCOs that treat members with higher than average health care needs.

Recommendations for State Agencies (PM-SR-3)

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

8. COORDINATION OF CARVE-OUT SERVICES

A. Introduction

In the current 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. The number and variety of services carved out of the Medi-Cal managed care program in California create the potential to leave members at risk for being lost between systems, with consequential negative impacts on care. Due to the fragmentation between certain carve-out services and the health plans, the burden for coordinating services often falls on the beneficiaries and their families.

Example

If a child is receiving services through an MCO for a chronic condition such as asthma, the MCO coordinates all asthma-related care (e.g., ensure that all needed medical appointments are scheduled, transportation arranged, appropriate medications are prescribed and filled). If that same child develops an emotional disorder, then care related to the emotional disorder would be delivered outside of the MCO via the county-based mental health system. Because of the fragmentation of the carve-out system, the MCO would have little or no knowledge of the mental health service the child receives and the county-based mental health plan would have little to no knowledge of the asthma care. In order to increase the quality of life and health status, it is important for both sides to have an understanding of the child’s full range of health care needs. In a well coordinated carve-out system, both entities providing care would share information and work together to maintain ongoing management of the child’s asthma as well as appropriate treatment for the emotional disorder.

The consultant team held two workgroup sessions to identify ways to ensure that better collaboration, coordination, and communication occurs among providers and MCOs. Representatives from many of the state agencies that provide services to Medi-Cal beneficiaries participated in the workgroup sessions.

The California Health and Human Services Agency (CHHSA), with its oversight of all the various providers of care, is in the best position to develop and implement a system to help ensure that members’ care is coordinated. As a result, the proposed recommendations are targeted to both CHHSA and the legislature and will require CHHSA leadership to implement.

The recommendations in this section were based on the following workgroup values:

- A focus on the provision of member-centered care;
- An expectation of mutual responsibility and accountability for coordination of carve-out services across state, local agencies, the MCOs, providers, and the members themselves; and
- An understanding that agencies need to exchange information and data smoothly to coordinate systems of care.

This section provides recommendations that aim to ensure that Medi-Cal members with disabilities and chronic illnesses find coordination between the managed care plan and carve-out services to be as seamless and easy to navigate as possible. The recommendations assume that the current Medi-Cal program design for carve-out services will not change in the near future (e.g., the services noted above will continue to be carved-out).

The Medi-Cal MCO contract contains provisions related to the coordination of carve-out services, including a requirement that MCOs must include information about carve-out services in the Member Services Guide, develop and maintain procedures for referral and coordination of care to carve out providers; and execute a Memorandum of Understanding (MOU) with certain carve-out providers (e.g., specialty mental health providers). However, based on workgroup feedback, these contract provisions appear to be largely unsuccessful in achieving their goal of care coordination in many other areas of the health system. Much of this can be due to a lack of clarity around the responsibilities of various organizations for coordination: poor information sharing and inadequate state oversight over carve-out service providers. Also, MCOs noted that the carve-out providers have little incentive to “come to the table” because there is no requirement for them to coordinate with the MCOs. In some cases, such as the California Children’s Services (CCS) program, the MOU with the health plans has proven to work well in promoting coordination and information sharing. Part of the success of this MOU relationship can be attributed to a close oversight of the MCO/CCS relationship by CDHS, a clearer understanding by the entities on how they should work together, and a willingness to share health-related information.

B. Key Recommendations for the California Department of Health Services and Other State and Local Agencies

Summary Recommendations

Establish a state-level memorandum of understanding.

Develop a local level memoranda of understanding.

Clarify payment responsibilities.

1. *Establish a State-level Memorandum of Understanding*

The current system of Medi-Cal carve-out services has created numerous coordination challenges for members. There are demonstrable breakdowns in the system around providers understanding what payer entity is responsible for claims payment for certain services (especially around behavioral health) and a perception that several departments within CHHSA do not have strong oversight of providers of carve-out services or meaningful internal coordination. While this may not be true for all of the departments, overall there appears to be a lack of internal coordination. The recommendation for a state-level MOU is intended to create a structure of accountability at the state level to assist in improving coordination on a system-wide basis.

Recommendation for State Agencies (CO-SR-1)

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

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

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

2. *Develop a Local-Level Memoranda of Understanding*

As noted above, the current system of Medi-Cal carve-out services creates many care coordination challenges that need to be addressed at the state level. Limited care coordination exists at the local level, as well. In particular, workgroup members expressed concern with the lack of coordination between county mental health providers and MCOs and between Regional Centers and MCOs. Currently, the MCO contract requires it to enter into an MOU with certain local carve-out providers. However, workgroup input suggests that the MOU between the MCO and the carve-out provider is not a priority for either organization and is rarely developed and executed, leaving both MCOs and carve-out providers without a guide or expectation for how to coordinate care.

In order to address the “care coordination disconnect,” it would be ideal for CHHSA to renew its commitment to the local MOU concept. CHHSA should continue to require the use of a local-level MOU in the MCO contract, require its departments to ensure that carve-out providers have the same MOU requirement, and take the lead in developing a more robust and useful MOU template than is currently provided. The MOU shall contain the elements noted below to ensure that all participants in a carve-out service system have a clear understanding of the expectations. In addition, the MOU should provide some flexibility for regional variation.

Another mechanism for developing relationships and processes to better coordinate care across a carve-out system is a Local Interagency Team. The Local Interagency Team model is designed to bring all the providers together to discuss shared individual cases that require a significant amount of service and to agree on the best-coordinated care plan. Through a Local Interagency Team model, state agencies, regional centers, MCOs, and other relevant providers in a carve-out system would meet regularly in order to establish common goals, coordinate responsibilities, and solve problems related to coordination across systems focused on complex, high-need members. Similar models are currently operating in San Francisco, Louisville (KY), and North Carolina.

If CHHSA decides to pursue implementation of the Local Interagency Team model, then the guidelines for local interagency team participation should be established by the state in the local MOU. The local MOU should allow flexibility for already existing Local Interagency Team-like models to continue.

Recommendation for State Agencies (CO-SR-2)

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

- Establish the Basic Elements of Care Coordination: Establish requirements for activities needed for coordination of carve-out services. This will ensure that each organization serving members in a carve-out system will have the same expectations for responsiveness. For example, the MOU should establish response time requirements for inquiries from

carve-out system partners (e.g., any phone call about a shared member should be returned within 24 hours) and establish a process to inform carve-out system partners about the correct staff contacts (e.g., supply carve-out partners with updated contact lists of agency staff on a quarterly basis).

- **Interagency Team Development:** Establish and delineate the responsibilities of a Local Interagency Team initiative designed to assist in coordinating care.

3. *Clarify Payment Responsibilities*

As noted in the state-level MOU recommendation, significant confusion exists in the carve-out system over the identification of the appropriate party for claims payment. This confusion can cause services to be denied and/or service delivery to slow. For example, when an infant is identified by a Regional Center's Early Start Program as having a complex developmental delay, the Regional Center may refer the infant to a provider without checking to see if the provider is part of the infant's MCO network. In this scenario the Regional Center may pay an out-of-network provider to begin the treatment services for the infant. Once the MCO discovers the infant is seeing an out-of-network provider, it may be uncertain about who should pay for the infant's services. The MCO may attempt to move the infant to an in-network provider. The family may be concerned that neither system will pay, or be forced to change providers mid-stream. The state can prevent this type of problem by clearly delineating the responsible party where disputes are most likely to arise, so that care can move forward appropriately and provider and patients can be confident that it will be covered. It is essential that payment and policy clarifications are made available to members, providers, and Medi-Cal contractors.

Recommendation for State Agencies (CO-SR-3)

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

CHHSA should use the following mechanisms to communicate payment clarification:

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

the foundation for its matrix.).

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

III. CONCLUSION

The recommendations in this report address areas of the Medi-Cal managed care contract that should be enhanced in order to better prepare both health plans and the state for an expansion of the number of people with disabilities and chronic conditions enrolled in the Medi-Cal managed care program. Factors such as timing, the cost implications for health plans to implement the recommendations compared to the benefits to be accrued to the consumers, health plans, and state, and the lessons learned from other states will be important for CDHS to consider as it embarks on its own prioritization processes.

The chart below is an at-a-glance summary of all of the recommendations presented in this paper. The consultant team ranked each recommendation as either essential, important, or ideal to have in place based on an assessment of the current program, experience of other states or health plans with similar provisions, expected cost, and expected impact and benefits. The criteria for the rankings is as follows: (1) **essential** requirements should be in place for Medi-Cal managed care models that mandate enrollment of people with disabilities and chronic conditions, including some current counties as well as proposed expansion areas; (2) **important** provisions would bring California in line with other state Medicaid managed care programs and should be in place for a mandatory program, but are not required prior to the initial transition period; and (3) **ideal** recommendations would move California closer to a system that embraces the guiding principles outlined in the summary chapter and could catapult California as a national leader in serving people with disabilities and chronic conditions, but could be implemented over a longer time horizon than recommendations considered “essential” or “important.”

Recommendation Summary Chart

Recommendation		Priority 1 (essential) 2 (important) 3 (ideal)
Cross Cutting Issues		
CC-CR-1	MCO shall conduct disability literacy and competency training	2
CC-CR-2	MCO shall conduct initial screen for new members to identify health and accommodation needs (if not completed by enrollment broker)	1
CC-CR-3	MCO shall promote meaningful consumer participation in health plan decision-making and advisory processes	1
CC-SR-1	State should develop and implement statewide education strategy for providers, including standardized training materials	3
CC-SR-2	State should develop a standard initial health screen and require the enrollment broker and MCOs to attempt to screen all new members	1

Recommendation		Priority 1 (essential) 2 (important) 3 (ideal)
CC-SR-3	State should provide MCOs with member-specific, historical FFS claims data for those transitioning from FFS to managed care, and utilization data for carve-out services on an ongoing basis	1
CC-SR-4	State should continue to improve mechanisms for informing consumers of the multiple avenues available for appeals	3
CC-SR-5	State should engage local representation to discuss issues related to expansion of managed care	2
CC-SR-6	State should develop and support an independent, community-based system to help beneficiaries navigate the system	2
CC-SR-7	State should encourage cooperation of A&I branch and MMCD in development of audit standards for new contract requirements	2
Enrollment and Member Services		
ES-CR-1	MCO shall work with FFS providers and other MCOs to maintain continuity of care for persons transitioning from FFS or other MCOs during the 60-day transition period	1
ES-CR-2	MCO shall provide support and member advocacy for members with disabilities and chronic conditions	2
ES-CR-3	MCO shall provide the member services guide in alternative formats within 7 business days and other materials in a timely fashion	1
Network Capacity		
NC-CR-1	MCO shall conduct an enhanced facility site review to assess the physical and non-physical accessibility of provider facilities and communicate accessibility to members	1
NC-CR-2	MCO shall develop and implement accommodation policies and procedures for enabling members to access services	1
NC-CR-3	MCO shall develop and file an annual ADA Accessibility Plan with CDHS	2
NC-CR-4	MCO shall provide members with a provider directory with information on the accessibility of individual provider offices	2
NC-CR-5	MCO shall use the telephone relay service as an additional mechanism for communicating with members with speech and hearing impairments	1
NC-CR-6	MCO shall provide an enhanced definition of a “medical home” for members with a disability or chronic condition	2
NC-SR-1	State should review the revised accessibility policies and procedures as part of the periodic audit of MCO compliance	3

Recommendation		Priority 1 (essential) 2 (important) 3 (ideal)
NC-SR-2	State should use modified contractual definitions related to accessibility	2
NC-SR-3	State should consider current community standards of care and/or other standards when considering MCO requests for exceptions from time and distance standards	2
Benefit Management		
BM-CR-1	MCO shall review the criteria used to make coverage decisions for new technology and investigational treatments	2
BM-CR-2	MCO shall use a qualified physician with appropriate expertise with the members' condition or disease to review all denials	2
BM-CR-3	MCO shall arrange for provision of medically necessary services from specialists outside the network if unavailable within network	1
Care Management		
CM-CR-1	MCO shall use enhanced definition of care management that combines case management and care coordination	1
CM-CR-2	MCO shall develop a care management program description	1
CM-CR-3	MCO shall use qualified care managers, preferably with experience and expertise serving people with disabilities and chronic conditions	2
CM-CR-4	MCO shall identify members needing care management	1
CM-CR-5	MCO shall develop care plans for persons identified as needing care management	1
CM-CR-6	MCO shall expand the DM program description to include specifics regarding how it will facilitate the participation of persons with disabilities and multiple conditions in DM	3
CM-CR-7	MCO shall assist members in coordinating out of plan services, particularly carve-out services	1
CM-SR-1	State should develop a working group to evaluate innovative practices and work with MCOs to adopt best practices	3
Quality Improvement		
QI-CR-1	MCO shall use member data to identify and stratify disabilities and/or condition(s) to develop targeted QI activities and interventions	1
QI-CR-2	MCO shall stratify utilization data by subcategories (e.g. SSI and TANF) of its Medi-Cal enrollees	1

Recommendation		Priority 1 (essential) 2 (important) 3 (ideal)
QI-CR-3	MCOs shall collect additional utilization data (e.g., DME and preventable hospitalizations)	2
QI-CR-4	MCO shall conduct a statewide quality improvement project on an issue related to people with disabilities and chronic conditions	2
QI-CR-5	MCO shall, on an ongoing basis, disseminate information to providers regarding best practices for treating people with disabilities and chronic conditions	3
QI-CR-6	MCO shall include on QI committees providers who represent a range of services used by members with disabilities and chronic conditions	2
QI-CR-7	MCO shall, as part of its QI System description, outline the QI activities that address services and clinical improvements relevant for people with disabilities and chronic conditions	2
QI-SR-1	For the first year of enrollment, the state should provide each MCO with stratified member data based on the most prevalent chronic conditions and disabilities	2
QI-SR-2	State should stratify risk-adjusted utilization data and provide these results to MCOs in aggregate form	1
QI-SR-3	State should conduct a statewide collaborative quality improvement project on a topic related to people with disabilities and chronic conditions	2
QI-SR-4	State should facilitate one quality improvement project to improve quality and coordination of care across MCOs and carve-out services	2
QI-SR-5	State should work toward identifying and resolving gaps in clinical guidelines for people with disabilities and chronic conditions	3
Performance Measurement		
PM-CR-1	MCO shall stratify certain External Accountability Set/HEDIS measures	1
PM-CR-2	MCO shall collect and stratify additional HEDIS measures	1
PM-SR-1	State should charge the MMCD Quality Improvement Committee with identifying three new non-HEDIS measures to pilot test	2
PM-SR-2	State should develop and administer an enhanced statewide consumer satisfaction survey tailored towards issues for people with disabilities and chronic conditions	1
PM-SR-3	State should use financial and non-financial rewards to motivate MCOs to become high quality, high performing MCOs	3

Recommendation		Priority 1 (essential) 2 (important) 3 (ideal)
Coordination of Carve-out Services		
CCO-SR-1	Legislature should require the CHHSA departments with oversight of the carve-out service system to develop and execute a state-level MOU	1
CCO-SR-2	CHHSA shall develop a local level MOU to ensure participants in a carve-out system have a clear understanding of the expectations	3
CCO-SR-3	CHHSA should identify and clearly delineate the appropriate payer of Medi-Cal funded services and make the information easily available	1

California has the opportunity and responsibility to enhance the current Medi-Cal managed care contract to better reflect the differences in providing quality health care for people with disabilities and chronic conditions. These different needs range from safeguarding against a disruption of care during the transition period into managed care to requiring health plans to create a more robust care management process to measuring access, health care outcomes, and patient satisfaction. The state also has an obligation to further refine its processes to create a Medi-Cal managed care system that promotes accountability for itself and its health plans and ensure quality health care for all its members.

Enhanced contract standards are just part of what is needed to truly prepare CDHS for a large programmatic expansion. Over the next several months, the consultant team will develop recommendations for monitoring managed care contract compliance and a health plan readiness tool. These two products will provide further opportunity for the state to better prepare its Medi-Cal managed care program to meet the needs of people with disabilities and chronic conditions.

Appendix A

Workgroup Descriptions

Accessibility. Health plans must take appropriate steps to ensure program, physical, and communication access for all members. Compliance with the Americans with Disabilities Act and the Rehabilitation Act is critical to meeting such accessibility and non-discrimination principles. This workgroup covered contract requirements related to accessing health care services (e.g., member services hotline, geographical access, emergency services access, ADA site compliance, transportation, translation/interpreter services, alternative formats, etc.).

Benefit Management. Benefit packages for people with disabilities should allow health plans to manage the distinct needs of beneficiaries in the most appropriate and cost-effective setting. This group discussed issues related to benefit management such as the current Medi-Cal definition of medical necessity and the criteria and procedures used to determine medical necessity and the approval/denial of medical services. The use of out-of-network services and the process used to determine benefit exceptions and other types of service authorizations also were discussed. This group also addressed issues regarding the management of services for beneficiaries transitioning between health plans.

Coordination of Specialty Services. Medi-Cal carves-out numerous benefits from its health plan contracts. Issues related to enrollees transitioning between programs; the coordination between services; and the integration of enrollee information regarding services (mental health, alcohol and substance abuse treatment, developmental disabilities, and children's services) that are carved-in/out of managed care were addressed during this workgroup.

Care Management. Comprehensive care coordination/care management programs are essential to: ensure that beneficiaries have access to a medical home; link consumers to needed preventive services; coordinate the full array of services, including specialty services that are carved-out of managed care; and connect members to vital social and supportive services. This workgroup focused on the integration of all processes to ensure well-managed patient care (e.g., comprehensive health assessments, care plans, family involvement, and case management services) and determining which individuals will receive care management services.

Performance Measurement. Developing an all encompassing quality measurement program can be challenging for several reasons: individuals with disabilities vary enormously in the complexity and diversity of disability and condition; the prevalence of certain conditions is small; and evidence-based treatment guidelines may not be well-developed. This workgroup focused on identifying performance measures that could be used to evaluate the safety, effectiveness, timeliness, equitability, patient-centeredness, and efficiency of the services provided by the MCO. The workgroup also address what type of data MCOs should be required to share with the state.

Member Services. Member service functions are the gateway to helping a consumer understand a health plan's benefits, providers, and programs (such as health education and

care management). The workgroup focused on identifying ways to support and assist members in obtaining information about the MCO and its providers (e.g., call center functions; information contained in enrollment handbooks and provider directories; and use of alternative formats for education) This workgroup also discussed education and training for member services staff regarding services and materials available for people with disabilities.

Network Capacity. Managed care organizations must build a primary care and specialty network that has relevant expertise in serving people with disabilities and chronic illness. This workgroup addressed issues related to provider availability and access (e.g., network composition including primary and specialist networks, provider education/training, specialists as PCPs, appointment standards, use of centers of excellence, the type of provider, and network data collected, etc.)

Quality Improvement. The field of quality improvement in Medicaid managed care has advanced dramatically over the past several years and is now beginning to drive care enhancements for people with disabilities and chronic illness. This workgroup covered issues related to improving the quality of health care for people with disabilities in ways that move beyond traditional approaches (e.g., incentives, requirements for quality improvement projects, identifying and stratifying the target population, etc.).

Appendix B Workgroup Participants

Consumer Groups

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Linda Vossler-Swan, Family Voices

Health Plans

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Richard Bruno/ Carl Maier, Inland Empire Health Plan
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Appendix D
Ambulatory Sensitive Conditions

AHRQ Prevention Quality Indicators (Ambulatory Sensitive Conditions)

Source: AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions. Rockville, MD: Agency for Healthcare Research and Quality. Revision 4. (November 24, 2004). AHRQ Pub. No. 02-R0203.

Indicator Name (Number)	Description
Diabetes Short-term Complication Admission Rate (PQI 1)	Number of admissions for diabetes short-term complications per 100,000 population.
Perforated Appendix Admission Rate (PQI 2)	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area.
Diabetes Long-term Complication Admission Rate (PQI 3)	Number of admissions for long-term diabetes per 100,000 population.
Pediatric Asthma Admission Rate (PQI 4)	Number of admissions for pediatric asthma per 100,000 population.
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 5)	Number of admissions for COPD per 100,000 population.
Pediatric Gastroenteritis Admission Rate (PQI 6)	Number of admissions for pediatric gastroenteritis per 100,000 population.
Hypertension Admission Rate (PQI 7)	Number of admissions for hypertension per 100,000 population.
Congestive Heart Failure Admission Rate (PQI 8)	Number of admissions for CHF per 100,000 population.

Low Birth Weight Rate (PQI 9)	Number of low birth weight births as a share of all births in an area.
Dehydration Admission Rate (PQI 10)	Number of admissions for dehydration per 100,000 population.
Bacterial Pneumonia Admission Rate (PQI 11)	Number of admissions for bacterial pneumonia per 100,000 population.
Urinary Tract Infection Admission Rate (PQI 12)	Number of admissions for urinary infection per 100,000 population.
Angina without Procedure Admission Rate (PQI 13)	Number of admissions for angina without procedure per 100,000 population.
Uncontrolled Diabetes Admission Rate (PQI 14)	Number of admissions for uncontrolled diabetes per 100,000 population.
Adult Asthma Admission Rate (PQI 15)	Number of admissions for asthma in adults per 100,000 population.
Rate of Lower-extremity Amputation Among Patients with Diabetes (PQI 16)	Number of admissions for lower-extremity amputation among patients with diabetes per 100,000 population.

Appendix E State Resources

Medi-Cal Managed Care 2-Plan Model Contract

S. Rosenbuam, S. Wilensky and P. Shin. “Achieving “Readiness in Medi-Cal’s Managed Care Expansion for Persons with Disabilities: Issues and Process.” (California: The California Endowment, 2005).

Federal Medicaid managed care regulation (Code of Federal Regulations Title 42 Part 438)
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html

California Code (statute), includes Welfare and Institutions Code and Health and Safety Code
www.leginfo.ca.gov/calaw.html

California Code of Regulations (regulation)
ccr.oal.ca.gov/

Arizona Health Care Cost Containment System Administration Medicaid Managed Care Contract
www.ahcccs.state.az.us/Contracting/ContractAmend/ALTCSCYE2003/CYE2003EPDFFinal.pdf

Oregon Medicaid Managed Care Contract
www.dhs.state.or.us/healthplan/data_pubs/contracts/contr_fchp_1004a.pdf

Pennsylvania Medicaid Managed Care Contract
<http://www.dpw.state.pa.us/omap/hcmc/hcagr/pdf/2004StandardContract.pdf>

New Jersey Medicaid Managed Care Contract
<http://www.state.nj.us/humanservices/dmahs/hmo-vol1.pdf>

Michigan Medicaid Managed Care Contract
http://www.michigan.gov/documents/contract_7696_7.pdf

New York Medicaid Managed Care Contract
<http://www.health.state.ny.us/nysdoh/mancare/macont0105.pdf> *Appendix J* – New York State Department of Health, Federal Guidelines on Americans with Disabilities Act

Texas HHSC Medicaid/CHIP Joint HMO RFP Operations Phase Requirements
www.hhsc.state.tx.us/medicaid/rfp/52904272/final/Section08.pdf

Wisconsin Department of Health and Human Services “BadgerCare” Medicaid Managed Care Contract
www.dhfs.state.wi.us/medicaid7/providers/pdfs/mc10051.pdf

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- ¹⁹ US Department of Health and Human Services. op. cit.
- ²⁰ Six Sigma. http://www.isixsigma.com/dictionary/Quality_Improvement-34.htm (25 October 2005)
- ²¹ L. Chimento, et al. Op cit.
- ²² California Department of Health Services, Medi-Cal Managed Care Division. "Improving Quality of Care in Medi-Cal Managed Care," May 2004, <http://www.dhs.ca.gov/mcs/mcmcd/pdf/Quality%20Strategy%20Final.pdf>
- ²³ Academic Detailing involves visiting a physician in his/her office to provide information on a specific topic based on best available evidence.
- ²⁴ For a full description of these measures, visit the NCQA website at www.ncqa.org/Programs/HEDIS/index.htm
- ²⁵ Vopel, A., O'Brien, J, Wiener. "Strategies for Assessing Health Plan Performance on Chronic Diseases: Selecting Performance Indicators and Applying Health-Based Risk-Adjustment." Center for Health Care Strategies. March 2005.
- ²⁶ For full listing of supplemental items visit: <http://www.cahps-sun.org/Products/Healthplan/HP-InstrumentOverview.asp>