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# Raising the Bar:
## How Medi-Cal Strengthened Managed Care Contracts for People with Disabilities

*Prepared for*
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*by*
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## About the Author

Kathy Moses is a senior program officer at the **Center for Health Care Strategies.** CHCS is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations who are experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its program priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. For more information, visit www.chcs.org.

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*The process used in California to address the needs of Medi-Cal-only seniors and people with disabilities could be used in other states and with other Medicaid populations that might be enrolled in managed care.*

## Introduction

In November 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's request to require most seniors and people with disabilities (SPDs) with Medicaid — but no Medicare — to enroll in capitated managed care plans.[1] From June 2011 through May 2012, 380,000 SPDs were affected by this policy change.[2] There are now over 700,000 SPDs with Medi-Cal (California's Medicaid program) enrolled in managed care.[3] This change is intended to improve health outcomes and slow the growth in Medi-Cal spending.

Prior to submitting its request to CMS, the California Department of Health Care Services (DHCS) convened a workgroup to consider the proposed expansion of mandatory managed care for SPDs with Medi-Cal. Advocates representing low-income people and people with disabilities were concerned that managed care plans were not prepared for a large influx of SPDs, did not have the systems in place to coordinate care for this high-cost population, and had incentives to withhold some services. The advocates were also concerned that DHCS was not prepared to monitor access and quality of care for this population.

To allay these concerns, consumer advocates and other workgroup participants were eager to see DHCS adopt recommendations that arose from a project organized and funded by the California HealthCare Foundation in 2005 to suggest ways of strengthening the Medi-Cal program's contracts with managed care plans. These contracts cover a range of areas, including: outreach and enrollment; member services; provider network characteristics; accessibility to health care providers, member materials, and services; care management; performance measurement; and quality improvement. The contracts are the state's primary mechanism to establish requirements for managed care plans, measure plan performance, and hold plans accountable.

The CHCF-led project, conducted in collaboration with DHCS, sought to ensure that the state's plan contract requirements address the needs of non-elderly adults with disabilities. Many of these individuals have multiple and complex chronic conditions and rely on services covered by Medi-Cal but not traditionally provided by Medi-Cal managed care plans, such as mental health services, in-home personal care services, and long-term care.

A multi-stakeholder advisory group and eight workgroups included over 100 people representing consumer groups, health plans, providers, and multiple state agencies, associations, and other organizations. They reviewed the state's existing managed care contracts and the contracts of other state Medicaid programs considered to represent best practices. They identified and debated the pros and cons of potential contract changes, and helped establish contract-requirement selection criteria priorities.

The result of this work was the development of 53 recommendations for performance standards across eight contract areas.[4]

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

The recommendations were divided into three categories: (1) **essential** requirements to have in place for Medi-Cal managed care initiatives that mandate the enrollment of people with disabilities and chronic conditions; (2) **important** provisions to bring California in line with other Medicaid managed care programs and to have in place for a mandatory system, though not necessarily essential for the early transition period; and (3) **ideal** recommendations that could be implemented over a longer-term horizon than recommendations in the first two categories. Of the 53 recommendations, 44 were categorized as essential or important (referred to in this report as "high-priority recommendations").[5] Of these 44 high-priority recommendations, 29 addressed opportunities for DHCS to improve Medi-Cal managed care contracts and 13 addressed other actions DHCS should take to improve the care of Medi-Cal beneficiaries with disabilities. Two of the high-priority recommendations were directed at the legislature or the California Health and Human Services Agency.

This report examines which of the 44 high-priority recommendations were adopted and which were not. It reviews the current Medi-Cal Managed Care Division's boilerplate contract and related policy letters.[6] The analysis was shared with DHCS staff to give them an opportunity to provide additional information regarding actions taken on the recommendations. Where the report determines recommendations were not adopted, it provides the rationale for this determination. Some recommendations are categorized as "in progress" — when significant efforts are underway to address the recommendation or it is too soon to determine if the recommendation has been adopted. The report concludes with an examination of the implications of expanding managed care for individuals enrolled in both Medicare and Medicaid (who are referred to as "dual eligibles").

## Findings

Of the 42 high-priority recommendations directed at DHCS, 29 (69%) were adopted (Table 1). Of the remaining 13 recommendations, eight were not adopted and five are in progress. Of those recommendations that require a revision to Medi-Cal contracts with managed care plans, 79% were adopted. By contrast, fewer than half (46%) of the recommendations that require other action by DHCS were adopted. The Appendix provides more detailed information on the status of each recommendation, including specific references to changes that have been made in Medi-Cal's managed care organizations (MCO) contracts.

### Cross-Cutting Issues

Several recommendations span a variety of issue areas, thus a cross-cutting issues category was developed. The issues included relate to: (1) training providers and MCO staff; (2) identifying and communicating specific member needs; (3) educating members and providers about the appeals processes; (4) assisting members with navigation of the managed care system; (5) ensuring that MCOs are compliant with requirements.

Six of the eight high-priority recommendations in the cross-cutting issues category of CHCF's 2005 report were adopted (Table 2, page 5). Two recommendations were not adopted. Language in the first of these two recommendations (CC-SR-6) specified:

> *"State should develop and support an independent, community-based system to help beneficiaries navigate the system."*

The intent of this recommendation was to ensure that members new to managed care would be assisted with MCO selection, program education,

**Table 1. Status of High-Priority Recommendations* to DHCS, by Category and Type**

| | TOTAL | ADOPTED | IN PROGRESS | NOT ADOPTED | PERCENT ADOPTED |
|---|---|---|---|---|---|
| **Category** | **42** | **29** | **5** | **8** | **69%** |
| Cross-Cutting Issues | 8 | 6 | 0 | 2 | 75% |
| Enrollment and Member Services | 3 | 3 | 0 | 0 | 100% |
| Network Capacity and Accessibility | 8 | 7 | 0 | 1 | 88% |
| Benefit Management | 3 | 2 | 0 | 1 | 67% |
| Care Management | 6 | 6 | 0 | 0 | 100% |
| Quality Improvement | 10 | 4 | 2 | 4 | 40% |
| Performance Measurement | 4 | 1 | 3 | 0 | 25% |
| **Type** | **42** | **29** | **5** | **8** | **69%** |
| Revision to Contract | 29 | 23 | 2 | 4 | 79% |
| Other State Action | 13 | 6 | 3 | 4 | 46% |

*Those categorized as essential or important. None of the high-priority recommendations in the category Coordination of Carve-Out Services were directed at DHCS.

**Table 2. Status of High-Priority Recommendations,* Cross-Cutting Issues**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 1 | MCO shall conduct disability, cultural competency, and sensitivity training. (CC-CR-1)† | Important | Adopted |
| 2 | MCO shall conduct initial screen for new members to identify health and accommodation needs (if not completed by enrollment broker). (CC-CR-2) | Essential | Adopted |
| 3 | MCO shall promote meaningful consumer participation in health plan decision-making and advisory processes. (CC-CR-3) | Essential | Adopted |
| 4 | State should develop a standard initial health screen and require the enrollment broker and MCOs to attempt to screen all new members. (CC-SR-2) | Essential | Adopted |
| 5 | 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. (CC-SR-3) | Essential | Adopted |
| 6 | State should engage local representation to discuss issues related to expansion of managed care. (CC-SR5) | Important | Adopted |
| 7 | State should develop and support an independent, community-based system to help beneficiaries navigate the system. (CC-SR-6) | Important | Not Adopted |
| 8 | State should encourage cooperation of A&I branch and MMCD in development of audit standards for new contract requirements. (CC-SR-7) | Important | Not Adopted |

*Those categorized as essential or important.

†Each recommendation is coded per the abbreviation assigned in the 2005 report. For example, CC-CR-1 is the first recommendation made in the cost-cutting issues (CC) category of performance measures. (CR) denotes that this recommendation refers to a contract requirement as opposed to another type of state requirement or action (SR). The text of individual recommendations has been shortened in this report. The full language of each recommendation can be found in the 2005 report.

and system navigation. The state's enrollment broker, Health Care Options (HCO), does have a telephone center to help members with MCO selection and offices in each county, but these existed prior to the implementation of managed care for the SPD population. This recommendation was made to extend the state's reach into the nonprofit social service system where people with disabilities and chronic conditions are already being served.

The other recommendation (CC-SR-7) not adopted in this category stated:

> *"Staff from the Medi-Cal Managed Care Division (MMCD) and the Audits and Investigations (A&I) 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. [DHCS] also should develop additional mechanisms to monitor compliance with essential or priority contract specifications."*

The intent of this recommendation was to ensure that MMCD and A&I would collaboratively develop and consistently apply audit standards that assess plans' abilities to meet program requirements. Although DHCS is conducting audits of network adequacy, there is no evidence of the recommended collaboration between MMCD and A&I. While the network adequacy audits are important, they do not fulfill the intent of the recommendation, which

is to develop tools to assess MCO compliance with new contract requirements that focus on people with disabilities and chronic conditions.

## Enrollment and Member Services

Recommendations in the enrollment and member services category were directed at the processes of enrolling new members in MCOs and providing them with the information they need to navigate the system throughout their connection to the MCO, particularly during transition from fee-for-service (FFS) to managed care. As beneficiaries with disabilities and chronic conditions move from FFS to managed care, a primary concern is the potential loss of their existing network of services. Thus it is important that their experience — from enrollment to ongoing interactions with member services — is managed effectively.

The 2005 report included three high-priority recommendations for strengthening MCO contracts in the area of enrollment and member services. All three recommendations have been adopted by DHCS and incorporated into its contracts with managed care plans (Table 3).

## Network Capacity and Accessibility

Unlike FFS programs that allow beneficiaries to see any participating provider, MCOs generally limit access to a network of providers representing the range of services and geographic areas assigned to the MCO. Network capacity and accessibility to appropriate providers is particularly important to people with disabilities and chronic conditions as they transition from FFS. They want to know that the providers in their MCO's network have the necessary clinical knowledge and disability competency.

Seven of the eight high-priority recommendations related to network capacity and accessibility were adopted (Table 4, page 7). One recommendation was not adopted. Language in this recommendation, NC-SR-2, specified that the "state should use modified contractual definitions related to accessibility" and included a list of eight specific definitions of accessibility that the state should incorporate into plan contracts. The intent of this recommendation is to broaden the concept of accessibility for people with disabilities and complex conditions. State policy letter PL 11-009 establishes that physical accessibility standards are required of plans but other domains of accessibility discussed in this recommendation (e.g., accessible website, alternative formats for member materials, auxiliary aides) are not covered in contract requirements.

**Table 3. Status of High-Priority Recommendations,* Enrollment and Member Services**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 9 | 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. (ES-CR-1) | Essential | Adopted |
| 10 | MCO shall provide support and member advocacy for members with disabilities and chronic conditions. (ES-CR-2) | Important | Adopted |
| 11 | MCO shall provide the member services guide in alternative formats within seven business days and other materials in a timely fashion. (ES-CR-3) | Essential | Adopted |

*Those categorized as essential or important.

**Table 4. Status of High-Priority Recommendations,* Network Capacity and Accessibility**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 12 | MCO shall conduct an enhanced facility site review to assess the physical and non-physical accessibility of provider facilities and communicate accessibility to members. (NC-CR-1) | Essential | Adopted |
| 13 | MCO shall develop and implement accommodation policies and procedures for enabling members to access services. (NC-CR-2) | Essential | Adopted |
| 14 | MCO shall develop and file an annual ADA Accessibility Plan with [DHCS]. (NC-CR-3) | Important | Adopted |
| 15 | MCO shall provide members with a provider directory that includes information on the accessibility of individual provider offices. (NC-CR-4) | Important | Adopted |
| 16 | MCO shall use the telephone relay service as an additional mechanism for communicating with members with speech and hearing impairments. (NC-CR-5) | Essential | Adopted |
| 17 | MCO shall provide an enhanced definition of a "medical home" for members with a disability or chronic condition. (NC-CR-6) | Important | Adopted |
| 18 | State should use modified contractual definitions related to accessibility. (NC-SR-2) | Important | Not Adopted |
| 19 | State should consider current community standards of care and/or other standards when considering MCO requests for exceptions from time and distance standards. (NC-SR-3) | Important | Adopted |

*Those categorized as essential or important.

## Benefit Management

Benefit management includes the procedures and processes established by MCOs and executed by licensed health care professionals to determine medical necessity and promote appropriate utilization of services. For beneficiaries, ensuring access to out-of-network services when necessary is very important. In addition, it is valuable for the individuals reviewing treatment requests to have expertise in issues facing people with disabilities and chronic conditions.

DHCS adopted two of the three high-priority recommendations related to benefit management (Table 5, page 8). One recommendation was not adopted. Language in this recommendation, BM-CR-1, stated:

> *"MCO shall consider the following when reviewing coverage policies or requests for new technology and investigational treatments: Scientific evidence should be priority. If it is not available for people with disabilities or chronic conditions, then professional standards or consensus expert opinion must be considered. Coverage should not be denied to people with disabilities in the absence of conclusive evidence."*

Although DHCS has contract language to address investigational services, utilization management, prior authorization, and review procedures, this recommendation was considered not adopted since a "professional standard or consensus expert opinion requirement" has not been included in the MCO contract language to specifically account for situations when evidence does not exist for people with disabilities.

**Table 5. Status of High-Priority Recommendations,* Benefit Management**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 20 | MCO shall review the criteria used to make coverage decisions for new technology and investigational treatments. (BM-CR-1) | Important | Not Adopted |
| 21 | MCO shall use a qualified physician with appropriate expertise in the members' condition or disease to review all denials. (BM-CR-2) | Important | Adopted |
| 22 | MCO shall arrange for provision of medically necessary services from specialists outside the network if unavailable within the network. (BM-CR-3) | Essential | Adopted |

*Those categorized as essential or important. None of the high-priority recommendations in the category Coordination of Carve-Out Services were directed at DHCS.

## Care Management

Care management in this document and in the original recommendations document is defined as a continuum of activities, including those previously described as case management and care coordination. While case management is used to describe the coordination of medical services after an acute event, care coordination is generally used to refer to the coordination of health and other services provided within and outside an MCO's scope of covered services. Both involve multidisciplinary teams and place the member at the center of care so that all domains of health needs are considered. Care management is essential for people with disabilities and chronic conditions, who often need specialized assistance to manage care provided by their MCO as well as carve-out and other support services provided outside of their MCO.

All six high-priority recommendations related to care management were adopted by the state (Table 6).

**Table 6. Status of High-Priority Recommendations,* Care Management**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 23 | MCO shall use enhanced definition of care management that combines case management and care coordination. (CM-CR-1) | Essential | Adopted |
| 24 | MCO shall develop a care management program description. (CM-CR-2) | Essential | Adopted |
| 25 | MCO shall use qualified care managers, preferably with experience and expertise serving people with disabilities and chronic conditions. (CM-CR-3) | Important | Adopted |
| 26 | MCO shall identify members needing care management. (CM-CR-4) | Essential | Adopted |
| 27 | MCO shall develop care plans for persons identified as needing care management. (CM-CR-5) | Essential | Adopted |
| 28 | MCO shall assist members in coordinating out-of-plan services, particularly carve-out services (CM-CR-7) | Essential | Adopted |

*Those categorized as essential or important.

## Quality Improvement

Quality improvement is an ongoing activity within an MCO focused on improving both clinical care and non-clinical processes that can have an impact on member health, costs, and utilization. Improving health care quality for people with disabilities and chronic conditions can be more difficult than doing so for a healthy population. Thus efforts around quality improvement should be specific to people with disabilities and chronic conditions.

Four of the 10 high-priority recommendations related to quality improvement were adopted and two are considered "in progress," since it is too early to determine if they have been adopted (Table 7).

Four recommendations have not been adopted. Three of these would require MCOs to collect and use utilization data of their members in specific ways.

> *"The MCO shall use member data to identify and stratify disabilities and/or condition(s) to developed targeted QI activities and interventions."* (QI-CR-1)

> *"The MCO shall stratify utilization data by subcategories (e.g., SSI and TANF) of its Medi-Cal enrollees."* (QI-CR-2)

> *"The MCO shall collect utilization data in the following areas: durable medical equipment (DME) and preventable hospitalizations."* (CI-SR-3)

**Table 7. Status of High-Priority Recommendations,* Quality Improvement**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 29 | MCO shall use member data to identify and stratify disabilities and/or condition(s) to develop targeted QI activities and interventions. (QI-CR-1) | Essential | Not Adopted |
| 30 | MCO shall stratify utilization data by subcategories (e.g., SSI and TANF) of its Medi-Cal enrollees. (QI-CR-2) | Essential | Not Adopted |
| 31 | MCO shall collect additional utilization data (e.g., DME and preventable hospitalizations). (QI-CR-3) | Important | Not Adopted |
| 32 | MCO shall conduct a statewide quality-improvement project on an issue related to people with disabilities and chronic conditions. (QI-CR-4) | Important | Adopted |
| 33 | MCO shall include on QI committees providers who represent a range of services used by members with disabilities and chronic conditions. (QI-CR-6) | Important | Adopted |
| 34 | 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. (QI-CR-7) | Important | Adopted |
| 35 | 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. (QI-SR-1) | Essential | Adopted |
| 36 | State should stratify risk-adjusted utilization data and provide these results to MCOs in aggregate form. (QI-SR-2) | Essential | Not Adopted |
| 37 | State should conduct a statewide collaborative quality-improvement project on a topic related to people with disabilities and chronic conditions. (QI-SR-3) | Important | In Progress |
| 38 | State should facilitate one quality-improvement project to improve quality and coordination of care across MCOs and carve-out services. (QI-SR-4) | Important | In Progress |

*Those categorized as essential or important.

DHCS did not add these requirements to its MCO contracts. As discussed in the next section, MMCD staff have expressed their interest in stratifying HEDIS and other data and including preventable hospitalizations among MMCD's 2013 HEDIS measures.

The other recommendation considered not adopted is QI-SR-2, which reads:

> *"State should stratify risk-adjusted utilization data and provide these results to MCOs in aggregate form."*

The two recommendations considered in progress are related to quality-improvement efforts. The recommendations include conducting a statewide quality-improvement project focused on the SPD population and conducting a quality-improvement project based on coordination of care across MCOs and carve-out services. While more time is needed to determine the outcome of these two recommendations, DHCS has demonstrated interest and willingness to adopt them.

## Performance Measurement

Performance measurement is an essential precursor to quality improvement. Measuring and monitoring health plan performance allows the state to identify areas that need improvement and focus quality-improvement efforts and resources based on these findings. General performance measures do not capture the full range of issues that are critical to the health care needs of people with disabilities and chronic conditions, thus developing specific performance measures for this population is critical.

One of the four high-priority recommendations related to performance measurement was adopted and the remaining three are in progress (Table 8). Language in the first recommendation, PM-CR-1, stated:

> *"MCO shall stratify certain HEDIS measures currently collected by MCOs (e.g., appropriate meds for people with asthma, breast and cervical cancer screening, and retinal eye exam for people with diabetes.)"*

The following measures are being considered for stratified reporting for the SPD population and can be found in the current "Proposed 2013 HEDIS

**Table 8. Status of High-Priority Recommendations,* Performance Measurement**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 39 | MCO shall stratify certain External Accountability Set/HEDIS measures. (PM-CR-1) | Essential | In Progress |
| 40 | MCO shall collect and stratify additional HEDIS measures. (PM-CR-2) | Essential | In Progress |
| 41 | State should charge the MMCD Quality Improvement Committee with identifying three new non-HEDIS measures to pilot test. (PM-SR-1) | Important | Adopted |
| 42 | State should develop and administer an enhanced statewide consumer-satisfaction survey tailored toward issues for people with disabilities and chronic conditions. (PM-SR-2) | Essential | In Progress |

*Those categorized as essential or important.

Measures for Full-Scope Plans" (draft proposal dated 12/12/11 provided by DHCS):

- Comprehensive Diabetes Care
- Children's and Adolescents' Access to Primary Care Practitioners
- Annual Monitoring for Patients on Persistent Medications
- Controlling High Blood Pressure
- Ambulatory Care (outpatient visits and emergency department visits)

Although these measures differ from those recommended in the 2005 report, they reflect the current thinking at DHCS and have been discussed with the plans. Stratified HEDIS measures had not been finalized at the time this report was finished, thus the "in progress" assessment of this recommendation.

PM-CR-2, the second high-priority recommendation considered "in progress," stated:

> *"MCO shall collect and stratify additional HEDIS measures (e.g., comprehensive diabetes exam, antidepressant med management, controlling high BP, 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)."*

Like the previous recommendation, the DHCS has the following measures under consideration as additional HEDIS measures. They can be found in the current "Proposed 2013 HEDIS Measures for Full-Scope Plans" (draft proposal dated 12/12/11 provided by DHCS):

- Comprehensive Diabetes Care
- Annual Monitoring for Patients on Persistent Medications
- Controlling High Blood Pressure

Again, the current list does not include all the measures recommended in the 2005 report but these measures reflect the current thinking at the DHCS and they have been discussed with the plans. The additional HEDIS measures had not been finalized at the time of this report, thus the "in progress" assessment of this recommendation.

PM-SR-2, the third recommendation identified as "in progress," specified:

> *"State should develop and administer an enhanced statewide consumer-satisfaction survey tailored toward issues for people with disabilities and chronic conditions."*

DHCS staff have expressed their intent to conduct the Consumer Assessment of Healthcare Providers and Systems in 2012 or 2013 and to separately report results for SPDs. Therefore, this recommendation was deemed "in progress."

## Coordination of Carve-Out Services

In the current Medi-Cal system, many of the services that are essential to people with disabilities and chronic conditions are carved out of the MCO and provided in an FFS environment by specialty care providers. These services include: specialty mental health; alcohol and substance abuse treatment; dental; California Children's Services; long-term care; home- and community-based waiver; and chiropractic. This fragmentation of care across specialists and the MCO could potentially put members at risk of being lost between systems and this would negatively impact their health care. The burden of coordinating care and services often rests on the members and/or their families.

Two high-priority recommendations were made in the 2005 report in the category Coordination of Carve-Out Services. Both of these recommendations were directed at entities other than the DHCS and are excluded from the above totals and percentages of recommendations directed at DHCS. The first recommendation (CCO-SR-1) is directed at the state legislature. The second recommendation (CCO-SR-3) is directed at the broader California Health and Human Services Agency (CHHSA), which has oversight of all the various health care programs. Sufficient action has not been taken by these two entities for either of the recommendations to be considered adopted (Table 9).

## Conclusion

DHCS has demonstrated a commitment to considering and incorporating the recommendations that arose from an extensive stakeholder examination of its oversight of managed care organizations serving non-elderly adults with disabilities who are enrolled in Medi-Cal. Of the 42 high-priority recommendations directed at DHCS, 29 were adopted, while five others are considered "in progress" and require additional time before quality-improvement and performance measurement can begin.

Strengthening Medi-Cal's contract standards to address the characteristics and needs of SPDs was a first step. Next, DHCS must ensure that the managed care organizations with which it contracts meet these standards and must hold them accountable for their performance. Also, because Medi-Cal policy and standards of practice evolve over time, stakeholders should periodically revisit the managed care contract standards with DHCS to ensure that the standards reflect any changes.

Last, the process used in California to address the needs of Medi-Cal-only SPDs could be used in other states and with other Medicaid populations that might be enrolled in managed care. For example, as of April 2012, California and 14 other states have proposed models for enrolling dual eligibles in capitated managed care. Changes would be necessary to reflect the full range of Medicare and Medicaid benefits for which managed care plans are responsible and the specific characteristics and needs of the population. The California experience demonstrates that a process like this could lead not only to meaningful improvements to the Medicaid program's managed care contract standards but could also help participants from different groups, such as disability advocates and health plan representatives, better understand each other's perspective and develop effective working partnerships.

**Table 9. Status of High-Priority Recommendations,* Coordination of Carve-Out Services**

| | RECOMMENDATION | PRIORITY | STATUS |
|---|---|---|---|
| 43 | Legislature should require the CHHSA departments with oversight of the carve-out service system to develop and execute a state-level, interagency MOU. (CCO-SR-1) | Essential | Not Adopted |
| 44 | CHHSA should identify and clearly delineate the appropriate payer of Medi-Cal funded services, which includes developing and maintaining a state-level Internet-based service matrix. (CCO-SR-3) | Essential | Not Adopted |

*Those categorized as essential or important. None of the high-priority recommendations in the category Coordination of Carve-Out Services were directed at DHCS.

## Endnotes

1. This request was made as part of California's 2010 Bridge to Reform waiver proposal and was approved by CMS under Section 1115 of the Social Security Act. Individuals residing in nursing facilities are exempt from this mandate.
2. Health plans are not capitated for all services. For example, long term care and mental health services are carved out of managed care in most counties.
3. This estimate includes dual eligibles and is based on DHCS counts of SPD enrollment in managed care of over 400,000, about half of whom were enrolled on a mandatory basis in one of California's County Organized Health Systems and half of whom were enrolled on a voluntary basis in a commercial plan or local initiative health plan.
4. *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions.* Prepared by the Center for Disability Issues and Health Professions, Center for Health Care Strategies, and the Lewin Group for the California HealthCare Foundation, November 2005.
5. Nine of the recommendations were categorized "ideal" and two were high-priority recommendations directed at entities other than DHCS (the legislature and the California Health and Human Services Agency). These are counted separately from the other 42 recommendations for the purpose of calculating percentages.
6. The contract reviewed for this study was the contract for health plans participating in the Two Plan model, which is the most prevalent model and the model with the greatest number of Medi-Cal enrollees.

# **Appendix:** Detailed Findings

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
|---|---|---|---|---|
| Cross-Cutting Issues (8) | | | | 6 |
| 1. CC-CR-1 | MCO shall conduct disability, cultural competency, and sensitivity training. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 1, Provision 10**<br>*Sensitivity Training*<br>Contractor shall ensure that all personnel who interact with SPD beneficiaries, as well as those who may potentially interact with SPD beneficiaries and any other staff deemed appropriate by Contractor or DHCS, shall receive sensitivity training.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 1, Item K**<br>Contractor shall submit policies and procedures for ensuring that all appropriate staff receive sensitivity training relating to SPD beneficiaries.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 7, Item F**<br>Contractor shall submit policies and procedures ensuring providers receive training on a continuing basis regarding clinical protocols, evidence-based practice guidelines, and DHCS-developed cultural-awareness and sensitivity instruction for SPD beneficiaries.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 7, Provision 5**<br>Contractor shall develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS-developed cultural-awareness and sensitivity instruction for seniors and persons with disabilities. This process shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to posting information on websites as well as other methods of educational outreach to providers.<br><br>**All Plan Letter 11-010**<br>*Specific Provisions for SPDs*<br>Requires that all health plan and provider staff be trained in DHCS-developed sensitivity curriculum. DHCS providing training for health plan trainers in web-based curriculum in January 2011. | ✔ |
| 2. CC-CR-2 | MCO shall conduct initial screen for new members to identify health and accommodation needs (if not completed by enrollment broker). | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 10, Provision 4**<br>*Health Risk Stratification and Assessment for SPD Beneficiaries*<br>Contractor shall apply a DHCS-approved health-risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher-risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS-approved health-risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk and 105 days for those determined to be a lower health risk. The health-risk stratification and assessment shall be done in accordance with W&I Code Sections 14182(c) (11) to (13) and MMCD Policy Letter 11-007.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 10, B–D**<br>B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including use of the Member Evaluation Tool (MET) and other health information used for risk stratification.<br>C. Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.<br>D. Submit the plan's risk-assessment tool to be used to comprehensively assess SPD beneficiaries' current health risk and help develop individualized care-management plans. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Cross-Cutting Issues (8), *continued* | | | | 6 |
| 3. CC-CR-3 | MCO shall promote meaningful consumer participation in health plan decision-making and advisory processes. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 1, Provision 9**<br>Contractor shall ensure that Medi-Cal members, including SPDs, or persons with chronic conditions, are represented and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Item 15**<br>Contractor shall form a community advisory committee (CAC) pursuant to Title 22 CCR Section 53876 (c) that will implement and maintain community partnerships with consumers, community advocates, and traditional and safety-net providers. Contractor 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. | ✔ |
| 4. 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. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 10, B–D**<br>B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including use of the Member Evaluation Tool (MET) and other health information used for risk stratification.<br>C. Submit Contractor's risk-stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.<br>D. Submit the plan's risk-assessment tool to be used to comprehensively assess SPD beneficiaries' current health risk and help develop individualized care-management plans. | ✔ |
| 5. 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. | Essential | **Policy Letter 11-003 Member Data**<br>DHCS is required to provide Plans with historical FFS claims data for beneficiaries upon their enrollment in the plans. This data will assist Plans with risk stratification and assessment of these members, the development of care-coordination plans for high-risk members, and the initiation of other care-management activities necessary to assure timely access to appropriate care for this new population.<br><br>Upon renewal of the Medi-Cal Eligibility Data System (MEDS) each month, DHCS will identify the Client Index Numbers (CINs) of Medi-Cal only SPD beneficiaries who are to be newly enrolled in managed care Plans as of the first of the upcoming month. DHCS will then extract from the department's data warehouse the FFS paid-claims data related to the identified CINs for the most recent 12 months available. This claims data will be divided into separate files created for each health Plan code (HPC). Each HPC file will contain only the data for the beneficiaries enrolled in that Plan in a single county. For Plans that operate in multiple counties, DHCS will create separate data files for each county in the Plans' service areas.<br><br>In addition to the claims-data file created for each HPC, DHCS also will create a separate file containing information on any currently approved FFS Treatment Authorization Requests (TARs) for the identified beneficiaries. As with the claims data, a separate TAR file will be created for each HPC. Attachment 2 provides the data elements, definitions, and layout for the TAR file.<br><br>Each Plan's designated responsible party for accessing these files will be notified via email when the monthly files have been placed in the folders at the SFTP site. This email also will contain a statistical report for each of the Plan's HPCs indicating the time period covered (by service date), the total number of CINs in the file, the number of CINs for which no FFS claims were available, the number of CINs with FFS claims, and the total claim records in the file.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 13, Provision 7, Item B**<br>If an SPD beneficiary does not select a Primary Care Provider within 30 days of the effective date of enrollment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing provider relationship for the purpose of Primary Care Provider assignment, including a specialist or clinic if an SPD beneficiary indicates a preference for either. Contractor shall comply with all federal and state privacy laws in the provision and use of this data. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| **Cross-Cutting Issues (8),** *continued* | | | | 6 |
| 6. CC-SR-5 | State should have a process for engaging local representation to discuss issues related to expansion of managed care to enroll people with disabilities or chronic conditions. | Important | Recommendation satisfied by development and implementation of the Advisory Group Meetings. Meeting minutes demonstrate that the group has representatives from health plans, community groups, and organizations knowledgeable of and interested in issues relating to the expansion of managed care. | ✔ |
| 7. CC-SR-6 | State should develop and support an independent, community-based system to help beneficiaries navigate the system. | Important | The intent of this recommendation was to assist members new to managed care with MCO selection, program education, and system navigation. The state's enrollment broker, Health Care Options (HCO), has a telephone center to assist members with MCO selection and offices in each county. However, this function existed prior to the implementation of managed care for the SPD population. This recommendation was made to extend the state's reach into the nonprofit social service system, where people with disabilities and chronic conditions are already being served. Therefore the requirements of this recommendation have not been met. | |
| 8. CC-SR-7 | MMCD and state A&I branch should cooperate in development of audit standards for new contract requirements. | Important | The intent of this recommendation was for DHCS's managed care division (MMCD) and the state's Audits and Investigations (A&I) branch to collaboratively develop and consistently apply audit requirements that assess plans' abilities to meet program requirements. Although DHCS is doing network-adequacy audits, there is no evidence of the recommended collaboration between MMCD and the A&I branch. While the network-adequacy audits are important, they do not fulfill the intent of the recommendation to develop tools to assess MCO compliance with new contract requirements focusing on people with disabilities and chronic conditions. | |
| **Enrollment and Member Services (3)** | | | | 3 |
| 9. 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. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Provision 16, Item C**<br>For SPD beneficiaries, Contractor shall provide continued access for up to 12 months to an out-of-network provider with whom they have an ongoing relationship (i.e., an existing provider from whom they are receiving services) if the provider will accept Contractor or Medi-Cal FFS rates, whichever is higher per W&I Code 14182(b)(13) and (14).<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 9, Item R**<br>Contractor shall submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a provider.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 13, Provision 7, Item B**<br>If an SPD beneficiary does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing provider relationships for the purpose of Primary Care Provider assignment, including a specialist or clinic if an SPD beneficiary indicates a preference for either. Contractor shall comply with all federal and state privacy laws in the provision and use of this data. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Enrollment and Member Services (3), *continued* | | | | 3 |
| 10. ES-CR-2 | MCO shall provide support and member advocacy for members with disabilities and chronic conditions. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item D**<br>Contractor shall allow or ensure the participation of the SPD beneficiary and any family, friends, and professionals of their choosing to participate fully in any discussion or decisions regarding treatments and services.<br>Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 10, B–C**<br>*Services for Persons with Developmental Disabilities*<br>B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W&I Code Section 14182(c)(10).<br>C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers, such as but not limited to respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental-services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 13, Provision 2, C**<br>Contractor shall ensure that Member Services staff provide necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues and referral to appropriate clinical-services staff. | ✔ |
| 11. ES-CR-3 | MCO shall provide the member services guide in alternative formats within seven business days and other materials in a timely fashion. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 13, Provision 4, B–C**<br>B. Contractor shall distribute the member information no later than seven calendar days after the effective date of the Member's enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit.<br>C. Contractor shall ensure that all written Member information is provided to Members at a 6th-grade reading level or as determined appropriate through the Contractor's group-needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.<br>1) Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.<br>2) Written Member-informing materials shall be provided in alternative formats (including Braille, large-size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.<br>3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 13, B**<br>Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations, and oral interpreters, including for those who are limited English-proficient or non-English speaking. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Network Capacity and Accessibility (8) | | | | 7 |
| 12. 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. | Essential | **Policy Letter 11-009 (Update to Policy Letter 00-002)**<br>Beginning February 1, 2011, in conjunction with Policy Letter 10-016, titled "Revised Facility Site Review Tool" and dated December 31, 2010, which requires plans to begin identifying provider site accessibility in their provider directories by using the Revised Facility Site Review tool.<br><br>Plan provider directories are now required to contain indicators that will identify the physical accessibility of provider sites, including specialists and ancillary service providers, that provide care to SPD beneficiaries. Provider sites will list accessibility indicators that meet identified elements from the revised Facility Site Review (FSR) tool.<br><br>In order to determine if a provider site earns an accessibility indicator(s), the following steps must be followed:<br>1) The health plan will evaluate each provider site using Attachment C of the FSR tool, in accordance with Policy Letter 10-016.<br>2) After the evaluation has been completed, it will use Table A to identify if any of the seven accessibility indicators meet the required elements. Table A is also included in Policy Letter 10-016.<br>For example, the first accessibility indicator listed in Table A is P for Parking. In order for a provider site to list the P accessibility indicator in a health plan provider directory, elements 3, 7, and 8 in Attachment C of the FSR tool must be met.<br>3) Once step two has been completed for all seven of the accessibility indicators, the health plan must add the accessibility indicator(s) to the reviewed provider site's entry in its provider directory.<br>4) In addition to listing the plan's accessibility indicators in the provider directory, a symbol indicating accessibility must be present before the word "Accessibility."<br>For example, the use of a wheelchair symbol followed by the word "Accessibility."<br>5) The final format plans must use in provider directories for indicating accessibility must include, at a minimum, a symbol, followed by the word "Accessibility," a colon (:), and the accessibility indicators with commas separating each indicator. | ✔ |
| 13. NC-CR-2 | MCO shall develop and implement accommodation policies and procedures for enabling members to access services. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Provision 11**<br>*Access for Disabled Members*<br>Contractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking-water provision.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 9, Item I**<br>Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.<br><br>*Also see #12, Policy Letter 11-009 (Update to Policy Letter 00-002)* | ✔ |
| 14. NC-CR-3 | MCO shall develop and file an annual ADA Accessibility Plan with [DHCS] and provide an annual update. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 9, Item I**<br>Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990. | ✔ |
| 15. NC-CR-4 | MCO shall provide members with a provider directory with information on the accessibility of individual provider offices. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 16, Provision 1**<br>Contractor shall cooperate with the DHCS Enrollment program and shall provide to DHCS's enrollment contractor a list of network providers (provider directory), linguistic capabilities of the providers, and other information deemed necessary by DHCS to assist Medi-Cal beneficiaries and Potential Enrollees in making an informed choice in health plans. The provider directory will be submitted every six months and in accordance with MMCD Policy Letter 00-02.<br><br>**Policy Letter 10-016**<br>See #12 for full description of accessibility measures. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Network Capacity and Accessibility (8), *continued* | | | | 7 |
| 16. NC-CR-5 | MCO shall use the telephone relay service as an additional mechanism for communicating with members with speech and hearing impairments. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Provision 13**<br>*Telecommunications Device for the Deaf (TDD)*<br>Included in the list of Linguistic Services that must be provided, at minimum. TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTYs, which are telephone typewriters or teletypewriters, or teletypes in general. | ✔ |
| 17. NC-CR-6 | MCO shall provide an enhanced definition of a "medical home" for members with a disability or chronic condition. | Important | **Two-Plan Boilerplate Contract Exhibit E, Attachment 1, Provision 65**<br>"Medical Home" means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive, and culturally competent. A Medical Home shall include, at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole-person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision-support tools, and continuous quality improvement; ready access to assure timely preventive, acute, and chronic-illness treatment in the appropriate setting; and payment that is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access, and quality-measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B). | ✔ |
| 18. NC-SR-2 | State should use modified contractual definitions related to accessibility. | Important | **Policy Letter 11-009 (Update to Policy Letter 00-02)**<br>*Policy Letter 00-016*<br>These letters both discuss the new language and requirements related to accessibility. See description under recommendation #12 (NC-CR-1) for more detail. | |
| 19. NC-SR-3 | State should consider current community standards of care and/or other standards for defining "urban," "rural," and "frontier" when considering MCO requests for exceptions from time and distance standards. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 6, Provision 8**<br>*Time and Distance Standard*<br>Contractor shall maintain a network of Primary Care Physicians located within 30 minutes or 10 miles of a Member's residence unless the Contractor has a DHCS-approved alternative time and distance standard.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Provision 4, Item D**<br>Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8, of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.<br><br>The DHCS currently uses community standards of practice when assessing exceptions to time and distance for accessibility. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Benefit Management (3) | | | | 2 |
| 20. BM-CR-1 | MCO shall consider the following when reviewing coverage policies or requests for new technology and investigational treatments: Scientific evidence should be priority. If it is not available for people with disabilities or chronic conditions, then professional standards or consensus expert opinion must be considered. Coverage should not be denied to people with disabilities in the absence of conclusive evidence. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 10, Provision 9**<br>*Investigational Services*<br>Contractor shall provide investigational services as defined in Title 22 CCR Section 51056.1(b) when a service is determined to be investigational pursuant to Section 51056.1(c) and ensure that all requirements in Section 51303(h) are clearly documented.<br><br>**Two Plan Boilerplate Contract Exhibit A, Attachment 5**<br>*Utilization Management*<br>Contract shall develop, implement, and continuously update and improve a Utilization Management (UM) Program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes: Established criteria for approving, modifying, deferring, and denying requested services. Contract shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and/or adoption of specific criteria used by the Contractor.<br><br>*Prior Authorization and Review Procedures*<br>Contractor shall ensure that its preauthorization, concurrent review, and retrospective review procedures meet the following minimum requirements: There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.<br><br>This recommendation was determined not to have been adopted since a "professional standard or consensus expert opinion requirement" has not been included in the MCO contract language to specifically account for situations when evidence does not exist for people with disabilities. | |
| 21. BM-CR-2 | MCO shall use a qualified physician with appropriate expertise with members' condition, disability, or disease to review all denials. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 5, Provision 2**<br>Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition or disease.<br><br>B. Qualified health care professionals will supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, in whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee or its equivalent. | ✔ |
| 22. BM-CR-3 | MCO shall arrange for provision of specialty services from specialists outside the network if unavailable within the MCO's network, when determined medically necessary. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 9, Provision 16**<br>A. If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and in timely fashion cover these services out of network for the Member for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.<br><br>B. Contractor shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity-of-care requirements in Health and Safety Code Section 1373.96.<br><br>C. For SPD beneficiaries, Contractor shall provide continued access for up to 12 months to an out-of-network provider with whom they have an ongoing relationship (i.e., an existing provider from whom they are receiving services) if the provider will accept Contractor or Medi-Cal FFS rates, whichever is higher per W&I Code 14182(b)(13) and (14). | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Care Management (6) | | | | 6 |
| 23. CM-CR-1 | MCO shall use enhanced definition of care management. "Care management includes identification and assessment of member needs, advocacy, facilitation, and coordination of plan, carved-out, and 'linked' services. 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." | Essential | **Two-Plan Boilerplate Contract Exhibit E, Attachment 1, Definitions, Items 12 and 17**<br>Care Coordination means services that are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person-Centered Planning, and Discharge Planning, and are included as part of a functioning Medical Home.<br>Complex Case Management means the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.<br>Although the contract language did not adopt the exact definition in the 2005 recommendations report, the MCO contracts reflect language to address the same components as "care management." In addition, DHCS has stated that the terms "complex case management" and "care management" are the same as they relate to the MCO contracts and that the complex case-management definition was modified as a result of this recommendation. | ✔ |
| 24. CM-CR-2 | MCO shall develop a care-management program description.<br>(See full recommendation in 2005 report for a description of all 12 recommended elements of the care-management program.) | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 4 (Quality-Improvement System), 7, I**<br>Contractor shall implement and maintain a written description of its QIS that shall include the following: Description of the activities, including activities used by Members who are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case-management, coordination, and continuity-of-care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.<br>Although the MCO contract language does not bullet out the 12 specific elements identified in the 2005 recommendation report, the MCO contracts include a requirement to describe the plan's care-management activities and also requires inclusion of activities specifically for the SPD population. | ✔ |
| 25. CM-CR-3 | MCO shall use qualified care managers, preferably with experience and expertise serving people with disabilities and chronic conditions. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item B, #2**<br>Complex Case-Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum: Management of acute or chronic illness, including emotional and social support issues, by a multidisciplinary case-management team.<br>Although the MCO contract language for qualified care managers does not specifically state a "preference for care managers with experience meeting the needs of people with disabilities and chronic conditions," the MCO contracts do include a requirement of a multidisciplinary care-management team that can encompass the appropriate expertise to serve the SPD population. | ✔ |
| 26. CM-CR-4 | MCO shall maintain procedures for identifying members for care management. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item D**<br>Contractor shall develop methods to identify members who may benefit from complex case-management services, using utilization data, the Health Information Form/Member Evaluation Tool, clinical data, and any other available data, as well as self and physician referrals. Complex case-management services for SPD beneficiaries must include the concepts of Person-Centered Planning.<br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 11, Item B**<br>Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case-management services. | ✔ |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Care Management (6), *continued* | | | | 6 |
| 27. CM-CR-5 | MCO shall develop care plans for persons identified as needing care management. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item D**<br>*Person-Centered Planning for SPD Beneficiaries*<br>1) Upon the enrollment of an SPD beneficiary, Contractor shall provide or ensure the provision of Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.<br>2) Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services and abilities.<br>3) Contractor shall allow or ensure the participation of the SPD beneficiary and any family, friends, and professionals of their choosing to participate fully in any discussion or decisions regarding treatments and services.<br>4) Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 18, Provision 10, Item D**<br>Submit the plan's risk-assessment tool to be used to comprehensively assess an SPD beneficiary's current health risk and help develop individualized care-management plans.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item B**<br>Complex Case-Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum: With Member and PCP input, development of care plans specific to individual needs and updating of these plans at least annually.<br><br>Although the contract language does not list all 20 specific elements from this recommendation, the MCO contracts reflect language to address Person-Centered Planning for SPD beneficiaries that meets the intentions of this recommendation. | ✔ |
| 28. CM-CR-7 | MCO shall assist members in coordinating out-of-plan services, particularly carve-out services. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 5**<br>Contractor shall implement procedures to identify individuals who may need or are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6-17 (Specialty Mental Health, Alcohol and Substance Abuse Treatment, Services for Children with Special Health Care Needs, CCS, Services for Persons with Disabilities, Early Intervention Services, Local Education Agency Services, School-Linked CHDP Services, HIV/AIDS, Dental, DOT for TB, WIC Supplemental Nutrition Program.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 11, Provision 1, Item A, #6**<br>Basic Case-Management Services are provided by the primary care provider in collaboration with the Contractor and shall include: Coordination of carve-out and linked services and referral to appropriate community resources and other agencies. | ✔ |
| Quality Improvement (10) | | | | 4 |
| 29. QI-CR-1 | MCO shall use member data to identify and stratify disabilities and/or condition(s) to develop and implement targeted QI activities and interventions. | Essential | This recommendation is not reflected in the MCO contract or policy. | |
| 30. QI-CR-2 | MCO shall stratify utilization data by subcategories (e.g., SSI and TANF) of its Medi-Cal enrollees. | Essential | This recommendation is not reflected in the MCO contract or in policy. | |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Quality Improvement (10), *continued* | | | | 4 |
| 31. QI-CR-3 | MCOs shall collect additional utilization data in the following areas: DME and preventable hospitalizations. | Important | This recommendation is not reflected in the MCO contract or in policy. | |
| 32. QI-CR-4 | MCO shall conduct a statewide quality-improvement project on an issue related to people with disabilities and chronic conditions. | Important | **All Plan Letter 11-021**<br>Contains the same statement as APL 11-002, which outlines the general requirements for QIPs. The new statewide collaborative will focus on all-cause hospital readmission and stratify data collection by SPDs. This will provide data for areas and subpopulations on which the next statewide collaborative could focus. | ✔ |
| 33. QI-CR-6 | MCO shall include on its QI Committee physicians and psychologists who represent a range of services used by members with disabilities and chronic conditions. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 4, Provision 4, Item A**<br>Contractor shall implement and maintain a quality improvement committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Medi-Cal members, including SPD beneficiaries and subcontractors who are representative of the composition of the contracted provider network, including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, and congestive heart failure), actively participate on the committee or medical subcommittee that reports to the QIC. | ✔ |
| 34. 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. | Important | **Two-Plan Boilerplate Contract Exhibit A, Attachment 4, Provision 7, Item I**<br>Contractor shall implement and maintain a written description of its QIS that shall include the following: Description of the activities, including activities used by Members who are SPD or persons with chronic conditions, designed to assure the provision of case-management, coordination, and continuity-of-care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management. | ✔ |
| 35. 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. | Important | **Policy Letter 11-003**<br>Provides details on the processes by which DHCS is providing Medi-Cal Managed Care plans with FFS data and Treatment Authorization Request data for the SPD population by individual beneficiary. | ✔ |
| 36. QI-SR-2 | State should stratify risk-adjusted utilization data and provide these results to MCOs in aggregate form. | Essential | **Medi-Cal Managed Care Division, Advisory Group Meeting**<br>Although minutes of the MMCD advisory group reflect that DHCS will provide risk-adjusted utilization data so that MCOs can identify incoming SPDs as high or low risk, there is no indication that the state plans to provide risk-adjusted and aggregated utilization data to MCOs on an ongoing basis. | |
| 37. QI-SR-3 | State should conduct a statewide collaborative quality-improvement project on a topic related to people with disabilities and chronic conditions. | Important | **All Plan Letter 11-021**<br>Contains the same statement as APL 11-002, which outlines the general requirements for QIPs. The new statewide collaborative will focus on all-cause hospital readmission and stratify data collection by SPDs. This will provide data for areas and populations that the next statewide collaborative could focus on. | In Progress |
| 38. QI-SR-4 | State should facilitate one quality-improvement project to improve quality and coordination of care across MCOs and carve-out services. | Important | **All Plan Letter 11-021**<br>Outlines the general requirements for QIPs. The new statewide collaborative will focus on all-cause hospital readmission and stratify data collection by SPDs. This will provide data for areas and subpopulations on which the next statewide collaborative could focus. The intent of the All-Cause Readmission statewide collaborative is to improve the quality and coordination of care across MCOs and carve-out services. | In Progress |

| | RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
|---|---|---|---|---|---|
| Performance Measurement (4) | | | | | 1 |
| 39. | PM-CR-1 | MCO shall stratify certain HEDIS measures currently collected by MCOs (e.g., appropriate meds for people with asthma, breast and cervical cancer screening, and retinal eye exam for people with diabetes). | Essential | **From: Proposed 2013 HEDIS Measures for Full-Scope Plans (Revised Proposal as of 12/12/11)**<br>The following measures are being considered for stratified reporting regarding SPDs in 2013:<br>• Comprehensive Diabetes Care<br>• Children's and Adolescents' Access to Primary Care Practitioners<br>• Annual Monitoring for Patients on Persistent Medications<br>• Controlling High Blood Pressure<br>• Ambulatory Care (outpatient visits and emergency dept visits)<br>These measures differ from those recommended in the 2005 report but reflect current thinking from the DHCS and have been shared with the plans. Stratified HEDIS measures had not been finalized at the time of this report, thus the "in progress" assessment of this recommendation. | In Progress |
| 40. | PM-CR-2 | MCO shall collect and stratify additional HEDIS measures (e.g., comprehensive diabetes exam, antidepressant med management, controlling high BP, 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). | Essential | **From: Proposed 2013 HEDIS Measures for Full-Scope Plans (Revised Proposal as of 12/12/11)**<br>The following measures are being considered for addition to the HEDIS measures:<br>• Comprehensive Diabetes Care<br>• Annual Monitoring for Patients on Persistent Medications<br>• Controlling High Blood Pressure<br>These measures do not include all of the measures recommended in the 2005 report but reflect current thinking from the DHCS and have been shared with the plans. Additional HEDIS measures had not been finalized at the time of this report, thus the "in progress" assessment of this recommendation. | In Progress |
| 41. | PM-SR-1 | State should charge the MMCD Quality Improvement Committee with identifying three new non-HEDIS measures to pilot test. | Important | **All Plan Letter 11-021**<br>Added five additional measures for reporting year 2012:<br>• Children's and Adolescents' Access to Primary Care Practitioners<br>• Immunizations for Adolescents<br>• Annual Monitoring for Patients on Persistent Medications<br>• Ambulatory Care (outpatient visits and ED visits)<br>• All-Cause Readmissions<br>DHCS routinely consults with the MMCD Quality Improvement Committee when identifying performance measures. | ✔ |
| 42. | PM-SR-2 | State should develop and administer an enhanced statewide consumer-satisfaction survey tailored toward issues for people with disabilities and chronic conditions. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 4, Provision 9, Item D (Consumer-Satisfaction Survey)**<br>At intervals as determined by DHCS, DHCS's contracted EQRO will conduct a consumer-satisfaction survey of a representative sample of members enrolled in Contractor's plan in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.<br>DHCS staff have indicated that they will contract with the EQRO to conduct the next survey of Medi-Cal managed care enrollees in 2012 or 2013, and that the next survey may oversample SPDs so that their results can be reported separately from other Medi-Cal members. | In Progress |

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Coordination of Carve-Out Services* (2) | | | | 0 |
| 43. | CCO-SR-1 Legislature should require the CHHSA departments with oversight of the carve-out services system to develop and execute a state-level interagency MOU. The MOU at a minimum should include ongoing audit activities and sharing of member data, and designate a staff person for oversight of the state-level MOU and service matrix that lists all Medi-Cal funded carve-out services. | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 12 (Local Health Department Coordination)**<br>1) Subcontracts for public health services to include "scope and responsibilities of both parties in the provision of services to Members, billing, and reimbursement requirements; reporting responsibilities and how services are to be coordinated between the local health department and the contractor, including the exchange of medical information."<br>2) Subcontracts or MOUs: Required for California Children Services, Maternal Child Health, Child Health and Disability Prevention Program, Tuberculosis Direct Observed Therapy, WIC, Regional Centers for Services for Persons with Developmental Disabilities, Local Governmental Agencies for Targeted Case-Management Services, and Mental Health.<br>3) Submission of "monthly reports by the contractor are required until such time as an MOU is executed. Report to document good-faith efforts to execute an MOU and the justification why such an MOU has not been executed.<br><br>**Two-Plan Boilerplate Contract Exhibit E, Attachment 2, Program Terms and Conditions - Access Requirements and State's Right to Monitor**<br>Authorized state and federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable federal and state laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during the Contractor's or other Facility's normal business hours. The monitoring activities will be either announced or unannounced.<br><br>**Other**<br>In addition, there are several recent health care system changes that promote coordination of care:<br>• Mental Health Care Consolidation, formation of Mental Health Managed Care.<br>• Five-year CCS pilot project to improve coordination of care. Two of the awardees have contracts with MMCD: Health Plan of San Mateo (COHS) and LA Care Health Plan (LI).<br>• MMCD, DMHC, and A&I workgroup established to improve audit processes.<br><br>DHCS believes that the contract language referenced above demonstrates its efforts toward adopting the recommendation and would like to point out that this requirement specifically states that the "legislature should require." DHCS has done what it can to ensure these requirements are met to the best of its ability. | |

*Coordination of Carve-Out Services is excluded from totals in the report because recommendations in this category are directed at entities outside of DHCS.

| RECOMMENDATION | | PRIORITY | DESCRIPTION / LOCATION | ADOPTED |
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| Coordination of Carve-Out Services* (2), *continued* | | | | 0 |
| 44. | CCO-SR-3 CHHSA should identify and clearly delineate the appropriate payer of Medi-Cal funded services, which includes developing and maintaining a state-level Internet-based service matrix that lists all carve-out services and appropriate payers | Essential | **Two-Plan Boilerplate Contract Exhibit A, Attachment 8 (Identification of Responsible Payer)**<br>Contractor shall provide the information that identifies the payer responsible for reimbursement of services provided to a Member enrolled in Contractor's Medi-Cal Managed Care health plan to DHCS's Fiscal Intermediary (FI) contractor. Contractor shall identify the subcontractor (if applicable) or Independent Physician Association responsible for payment and the Primary Care Provider name and telephone number responsible for providing care. Contractor shall provide this information in a manner prescribed by DHCS once DHCS and the FI contractor have implemented the enhancement to the California Automated Eligibility Verification and Claims Management System.<br><br>**MMCD All Plan Letter 07-012 (Identification of Regional Center Consumers)**<br>Monthly data file that will identify health plan members who are also Regional Center consumers. The Medi-Cal Managed Care Division collaborated with the Department of Developmental Services to provide this data file to health plans in order to facilitate the identification of health plan members also receiving services from a Regional Center. It is intended that the availability of this data will result in improved communication between the health plan and the Regional Center, ultimately improving coordination of care for plan members with, or at risk of, developmental disabilities.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 7, Provider Manual**<br>Contractor shall issue a Provider Manual and updates to the providers of Medi-Cal Services. The manual is a source regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, member grievance, appeal, and State Fair Hearing process and member rights information.<br><br>**Two-Plan Boilerplate Contract Exhibit A, Attachment 13, Member Services**<br>• Contractor shall develop and provide each Member or family unit a Member Services Guide that constitutes a fair disclosure of the provisions of covered health care services.<br>• Instructions on how a Member can view online, or request a copy of, Contractor's nonproprietary clinical and administrative policies and procedures.<br>• Contractor shall ensure the Medi-Cal members are notified in writing of any changes in the availability or location of Covered Services.<br><br>DHCS maintains a Provider Manual available on the DHCS website, with monthly updates emailed to all Medi-Cal providers. This manual clearly identifies what providers should do for managed care, FFS, and other programs operated by DHCS. This is in addition to the managed care provider manual provided through our health plans. Please visit www.medi-cal.ca.gov to view the Provider Manual and Provider Bulletins.<br><br>Similar to the previous recommendation, DHCS believes that the contract language referenced above demonstrates its efforts toward adopting the recommendation and would like to point out that this requirement specifically states that the "CHHSA should identify/delineate." DHCS has done what it can to ensure this recommendation is met. | |

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