

**ASSESSING THE ADEQUACY OF MEDICAID MANAGED
CARE PROVIDER NETWORKS**

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EXECUTIVE SUMMARY

I. Project Overview

The tremendous increase in Medicaid beneficiaries receiving health care services through managed care arrangements has led to a corresponding increase in efforts at the federal and state levels to improve the quality of care delivered by Managed Care Organizations (MCOs). One of the key determinants of an MCO's ability to deliver quality services is the adequacy of its provider network regarding access and availability, network quality, and cultural competence. Ensuring that MCOs maintain adequate networks is an on-going challenge for administrators, especially given changing regulations, public pressure, and limited resources. The purpose of this report is to provide guidance to state administrators in improving their processes of assessing the adequacy of Medicaid managed care provider networks.

This report is not intended to be a statement of requirements or best practices that state administrators will be required, or expected, to follow. Rather, it is intended to serve as a resource for Medicaid program administrators as they address some of the emerging challenges in the area of provider network adequacy. It contains: 1) a summary of utilization information and assessment methods for twenty-five performance standards; 2) it offers examples of interventions and assessment tools employed by states and MCOs; and, 3) it provides a framework for incorporating new standards into provider network adequacy assessment processes.

The primary source of information for this report was interviews and surveys involving ten states and ten MCOs. Other information was acquired through a review and analysis of Medicaid managed care contracts, RFPs, and provider network adequacy-related regulations and standards. The information is intended to provide administrators with concrete examples of the types of activities taking place around provider network adequacy in states and MCOs.

II. Summary of Key Findings

The interview, survey, and contract review process revealed a wealth of information about the use of the twenty-five performance standards by the selected states and MCOs. This process revealed assessment methods the states and MCOs employed to track and measure performance, and the interventions they use to identify and correct problems. The standards included in this report are divided into three categories: Access to or Availability of Care, Network Quality, and Cultural Competence.

States – Performance Standards and Assessment Methods

Regarding the use of standards, study revealed:

- States are already using some or all of the standards to assess the adequacy of their networks;
- Some standards are used more universally than others. For example, the standards grouped under the heading “Access to or Availability of Care” are used frequently as

part of state assessment processes, while those grouped under “Cultural Competence” are used less often;

- The measures and methods used by states to assess network adequacy vary significantly from state to state, reflecting local practice standards, different geographic conditions, and specific demographics of state Medicaid programs;
- States with more mature managed care programs are generally more likely to focus their assessment methods on quality issues, while those with less mature programs are more likely to focus on access issues;
- States are flexible in the application of the standards, recognizing that circumstances may create valid reasons to grant exceptions;
- States are unlikely to evaluate the adequacy of an MCO’s network based on a single standard. Instead states consider the standard within the context of the MCO’s overall performance;
- States are more likely to attribute the source of standards to the contractual process than to the regulatory process, perhaps reflecting the states’ shift away from a regulatory approach to purchasing health services to a more market-based approach; and,
- States have moved beyond the federally-mandated standards when they find those standards to be inadequate for their purposes.

The study revealed that state Medicaid agencies assess MCO performance through a variety of methods, depending primarily on the nature of the standard and the structure of the state program. Four general categories of assessment were identified in the survey and interview process: on-site reviews and desk audits, periodic reports, member feedback, and provider contact. Although most assessment methods fall into one of these categories, states rarely use the same assessment method for the same performance standard. The most commonly employed assessment methods were related to member feedback, obtained through complaints or satisfaction surveys.

MCOs- Performance Standards and Assessment Methods

The study revealed that:

- MCOs are already using some or all of the standards in assessing the adequacy of their networks;
- Some standards are used more universally than were others. For example, as do the states, most MCOs use the standards grouped under the heading of “Access to or Availability of Care” as part of their assessment process, and use those grouped under “Cultural Competence” less often;
- The methods and measures employed by MCOs tend to change, becoming more complex and detailed as MCOs mature;
- The measures used by MCOs to assess network adequacy are sometimes more stringent than those used by the states, indicating that their reasons for adopting and actively enforcing the standards go beyond the fact that they are required;
- The measures of network adequacy considered most important by MCOs differ from those considered most important by states; and,

- MCOs, particularly those operating plans in several states, are more likely to have gone beyond state standards when they find that the standards were inadequate for their purposes.

MCOs reported assessment methods that can generally be grouped under two headings: those that are used to measure performance in relation to the standards and those that are used to maintain compliance with state standards. The first generally produces information that goes beyond data required to meet state standards. Assessment methods that are simply used to maintain compliance generally yield only the information required. As was the case with the states, MCOs employed a number of assessment methods for each standard.

Interventions

As was observed regarding performance standards and assessment methods, states and MCOs use a variety of means to improve performance. States engage in an on-going struggle between the dual demands of their role as regulator and purchaser of health care services. In general, the interventions chosen by a state are determined by the way it approaches this role and defines its relationships with the MCOs. As a regulator, states may favor interventions that are proscriptive, developing interventions that are highly structured, and that incorporate performance measures that include little or no flexibility. However as purchasers, who rely on a dynamic market, states may favor interventions that utilize performance measures that are more flexible in order to account for the changing conditions in the market.

States and MCOs use a variety of means to assess Medicaid managed care provider network adequacy. This report includes some examples of the tools employed and describes how they are used. It also provides specific examples of network adequacy success stories reported by MCOs and states.

III. Considerations

As new developments in provider network adequacy come to light, either through federal legislation, HCFA initiatives, or state-sponsored activities, state administrators are faced with the problem of how to incorporate them into the operation of their Medicaid managed care programs.

There are several key questions that need to be addressed by Medicaid managed care administrators when they consider the incorporation of new provider network adequacy standards. These questions include:

- How does this standard improve access to, or the quality of care provided to Medicaid recipients?

- How does this standard fit the objectives of our Medicaid managed care program? How does it relate to our existing standards?
- What are the strengths and weaknesses of the existing provider networks in our state and how will this standard affect them?
- Is the standard realistic? Is it to collect and evaluate feasible the information needed to assess performance?
- What are the administrative, financial, and other resource cost implications of adopting this standard for the state and for the MCOs? Are the potential benefits worth the potential cost?
- What is our current relationship with the MCOs in the state and how will they react to this standard?

Answering these questions enables administrators to begin to sort through some of the issues involved in incorporating new standards, and will help them determine whether any action is required.

INTRODUCTION

The tremendous increase in Medicaid beneficiaries receiving health care services through managed care arrangements has led to wide-ranging efforts at the federal and state levels to improve the quality of care delivered by managed care organizations (MCOs). One of the key determinants of an MCO's ability to deliver quality services is the adequacy of its provider network. The passage of the Balanced Budget Act of 1997 (BBA) and the Health Care Financing Administration's (HCFA) adoption of the Quality Improvement System for Managed Care (QISMC) are two recent measures that address network adequacy.

Some of the proposed regulations and guidelines resulting from these and other activities in the managed care arena are similar to Social Security Act Section 1915(b) and 1115 waiver requirements, which many states have already incorporated into the operation and oversight of their Medicaid programs. However, there are some new themes and standards that require the attention of program administrators in order for the policy goals of improved quality of care to be put into effect.

Objectives of the Report

This report was developed in response to the recent legislative activity mentioned above, and to assist state administrators in improving the network adequacy assessment process in their states. Given the wide variety of network standards and assessment processes currently used by state Medicaid agencies, state administrators are faced with a challenge--as buyers and regulators of health care services-- to continuously improve their processes to ensure quality care.

PricewaterhouseCoopers (PwC) conducted a survey of ten state Medicaid programs and ten MCOs to determine how states and plans monitor network adequacy and respond to gaps in performance. As part of this process, PwC conducted a review of a sample of Medicaid managed care Requests for Proposals (RFPs) and plan contracts. In addition, PwC reviewed sample assessment tools provided by the study participants. This report summarizes the findings of those interviews, surveys and reviews, and provides some additional resources for state administrators.

This report is not intended to be a statement of requirements or best practices that state administrators will be required or expected to follow. It highlights only a small sample of proposed regulations, guidelines and other standards, with the intent of providing a resource administrators can use to address some of the challenges emerging in the area of provider network adequacy. The BBA-proposed regulations that are referenced in the document have not yet been finalized, as of the date of this report.

Organization of the Report

This report is organized into two major sections: Findings and Considerations. The content of these areas is as follows:

- Findings: This section discusses the findings of the interview and survey process as they pertain to the use of specific provider network adequacy standards and assessment methods, and the interventions used to correct problems once identified; and,
- Considerations: This section provides a general framework that can be applied by state policymakers and administrators in adopting new network adequacy standards.

The Methodology section, included in Appendix A, outlines the approach taken by HCFA and PwC to this project including the selection of interviewees, development of protocols, and review of contracts, RFPs, and assessment tools.

Using this Report

This report provides a summary of some of the standards, assessment methods, and interventions that are currently being used by states and MCOs. It includes sample contract language and highlights of some of the tools employed by states in the assessment of provider network adequacy and contains practical information that administrators may find useful in improving or adapting their approach to provider network adequacy.

Although the standards in this report were derived from a variety of sources, including BBA - proposed regulations and QISMC provision, they are not intended to serve as a list of suggested or required standards. They are simply examples of provider network adequacy standards.

This report can be helpful in assisting administrators in:

- Identifying the standards and performance measures that are or are not being used by states and MCOs;
- Identifying the assessment methods that are being employed by state administrators; and,
- Identifying successful interventions to improve provider network adequacy.

This report can also serve as a reference for provider network adequacy issues. The appendices contain several resources, including:

- A table listing the standards used in this study, the sources of those standards, and a summary of their use by states and by MCOs - Appendix B;
- Sample assessment tools and other documents used by states and plans – Appendix C;
- A Network Adequacy Worksheet to be used in conjunction with the framework provided in “Considerations” – Appendix D;
- A summary of some of the key BBA-proposed regulations relating to provider network adequacy – Appendix E; and,
- A copy of the QISMC Domain 3 provisions – Appendix F.

Introduction

As Medicaid managed care continues to evolve, provider network adequacy – access to or availability of providers, network quality, and cultural competence – will continue to remain an important issue, and this report should continue to serve as a useful resource for administrators.

FINDINGS: PERFORMANCE STANDARDS

The information summarized in this report was gathered through in-depth interviews and surveys involving ten states and ten MCOs. The interview protocol and the survey instrument were built around a list of twenty-five performance standards. These standards were chosen specifically for use in the interview protocol and survey and can be found in Appendix B. They were derived from BBA-proposed regulations, QISMC provisions, Health Plan Employer Data and Information Set (HEDIS) measures, and other selected sources. Although the standards were derived from these sources, in most instances the wording of the standard was altered and is not identical to the source. A further discussion of the methodology for the study can be found in Appendix A.

This section of the report summarizes responses regarding the use of the performance standards by the states and the MCOs and highlights the reported assessment methods for each of the standards.

The interview protocol (see Appendix A, Table 5) included questions about:

- The participants' general reaction to the standards listed;
- Whether the state or MCO thought the standards were useful in measuring network adequacy;
- Whether the state or MCO thought it feasible to collect the information required to assess the adequacy of the standards;
- Whether the state or MCO thought the standards needed to assess network adequacy should be more or less specific than those listed; and,
- Which areas the state or MCO found easy to assess and which they found particularly challenging.

The survey instrument (see Appendix A, Table 6) included questions about:

- Whether the state or MCO used the performance standards listed in the survey instrument;
- Whether the state or MCO had established performance levels for the standard;
- Whether the state or MCO used standards other than those indicated in the survey instrument;
- How the state or MCO assessed performance with regard to the standard; and,
- Whether the state or MCO monitored performance in meeting the standard.

The following section is presented in two major parts, a summary and analysis of the state responses and a summary and analysis of the MCO responses. Several issues are discussed: performance standards, performance measures, and assessment methods. For the purpose of this report: a performance standard is a requirement; a performance measure is a specific, measurable set of data that serves as a reflection of performance in relation to a particular standard; and an assessment method is a process for collecting and evaluating the data.

The performance standards are divided into three categories: Access to or Availability of Care, Network Quality, and Cultural Competence. These categories are loosely defined as follows:

- **Access to or Availability of Care:** Those standards whose purpose is to ensure member access to care or the availability of care to members;
- **Network Quality:** Those standards whose purpose is to ensure the delivery of high-quality services; and,
- **Cultural Competence:** Those standards whose purpose is to ensure that services are delivered in a manner that is sensitive to the needs of MCO members of different racial, ethnic, and cultural origins.

The following two pages contain an index to the discussion of each standard as it pertains to states and MCOs.

INDEX TO PERFORMANCE STANDARDS

STANDARD	Page Numbers	
	States	MCOs
Access to or Availability of Care		
1. PCP-to-member ratio.	19	49
2. For each provider type, including primary care providers, determine the following: the number and percentage that serve Medicaid patients; and the number and percentage that accept new Medicaid patients.	20	49
3. Provider turnover by provider type (including primary care providers).	22	50
4. MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands.	23	50
5. State standards regarding travel time and distance. MCO is in compliance with the state's standards regarding the maximum travel and distance times to PCPs and specialists. If no state standards, MCO has method for determining geographic access needs based on distance, travel times, and means of transportation.	24	51
6. MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services, and urgent care services.	26	52
7. MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	27	52
8. State standards regarding appointment waiting times. MCO is in compliance with the state's standards regarding appointment waiting times. If no state standards, MCO has method for determining and tracking appointment waiting times.	28	53
9. MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	29	54
10. The percentage of enrollees aged 20-44, 45-64, and 65 who had an ambulatory or preventive care encounter during the reporting year. Inpatient procedures, hospitalization, emergency room visits, mental health and chemical dependency are excluded.	30	54
11. MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventive services.	31	55
12. The MCO identifies providers whose facilities are accessible to people with disabilities.	32	55
13. The number of Perinatal Care Level II and Level III facilities in the provider network. The MCO has procedures in place to direct providers to the facilities.	33	56

STANDARD	Page Numbers	
	States	MCOs
14. Availability of translators in American Sign Language (ASL). MCO is in compliance with the state's standards regarding availability of translators in ASL. If no state standards, MCO has method for ensuring the availability of ASL translators.	34	56
15. Availability of TDD services. MCO is in compliance with the state's standards regarding TDD services. If no state standards, MCO has method for ensuring the availability of TDD services.	35	57
Network Quality		
16. State has process for ensuring the MCOs have relationships with public health, education, and social services agencies.	36	57
17. State evaluates MCOs credentialing and recredentialing process for all providers, including institutional providers.	37	58
18. Percentage of providers who receive initial orientation to the plan and on-going training from the plan.	38	58
19. MCO has procedures in place to timely identify and furnish care to pregnant women.	39	59
20. MCO has procedures in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	40	60
21. MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	41	60
Cultural Competence		
22. MCO has process for identifying significant sub-populations within the enrolled population that may experience special barriers in accessing health services, such as the homeless or certain ethnic groups.	42	61
23. Ratio of providers who speak a language other than English to the number of Medicaid recipients (total recipients, not just MCO members) who speak the same language.	43	61
24. MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and arrangements for interpreter services.	44	62
25. MCO offers cultural competency training that educates providers about the medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served.	45	63

**PERFORMANCE STANDARDS:
STATES**

All of the states in the sample responded to the survey and participated in the interviews. In general, they all used the standards to some degree as part of their process for assessing network adequacy.

Performance Standards

The study revealed that:

- States are already using some or all of the standards to assess the adequacy of their networks;
- Some standards are used more universally than others. For example, the standards grouped under the heading “Access to or Availability of Care” are used frequently as part of state assessment processes, while those grouped under “Cultural Competence” are used less often;
- The measures and methods used by states to assess network adequacy vary significantly from state to state, reflecting local standards of practice, different geographic conditions, and the specific demographics of state Medicaid programs;
- States with more mature managed care programs were generally more likely to focus their assessment methods on quality issues, while those with less mature programs were more likely to focus on access issues;
- States are flexible in the application of the standards, recognizing that circumstances may create valid reasons to grant exceptions;
- States are unlikely to evaluate the adequacy of an MCO network based on a single standard. Instead states consider the standards within the context of the MCO’s overall performance;
- States are more likely to attribute the source of standards to the contract process than to the regulatory process, perhaps reflecting the states’ shift away from a regulatory approach to purchasing health services to a more market-based approach; and,
- States have moved beyond the federally-mandated standards when they find those standards to be inadequate for their purposes.

Assessment Methods

The study revealed that state Medicaid agencies assess MCO performance in this area through a variety of methods, depending primarily on the nature of the standard and the structure of the state program.

Assessing provider network adequacy is a continuous process that takes place on several levels. The general framework and methods employed by state Medicaid agencies to assess provider network adequacy are similar, but there are marked differences in the choice of methods applied as well as their timing. In general, the survey revealed that four categories of assessment are used: *on-site reviews and desk audits, periodic reports, member feedback, and provider contact*.

The *on-site review and desk audit process* are rigorous and require that the MCOs demonstrate the adequacy of provider networks through policies and procedures,

documented processes, provider files, and other documentation. In the *on-site review*, the state reviews these materials at the MCO’s administrative offices and may conduct staff interviews. In the *desk audit* process, the state may request that copies of relevant materials be submitted to the agency.

The next review category consists of the submission of *periodic reports* by MCOs to the state about the condition of the network. These reports commonly are resubmitted on a monthly or quarterly basis and may include information such as the number of members assigned to a primary care provider (PCP), provider terminations, or utilization.

The third review category--reportedly one of the most closely monitored--is *member feedback*. This is conducted by monitoring complaints and soliciting member feedback through satisfaction surveys. The results are used as problem indicators and serve as red flags to administrators in identifying areas in need of improvement at the individual and network levels.

The fourth review category is conducted through *direct contact with providers*. In order to ascertain compliance with standards such as appointment availability, in-office waiting times, and 24 hour/ 7 day-a-week access, administrators will contact provider offices directly and ask questions that assist them in determining the level of performance in relation to each standard.

In response to the survey, most states and MCOs reported using assessment methods that fall into one of the above categories. However, variations existed within each category.

Standard Summary

To illustrate the findings related to the standards and assessment methods, the following section groups the standards under previously mentioned headings and describes how specific states assess each. It includes examples of specific state standards and performance measures as expressed in the RFPs and contracts of the states.

I. Access to or Availability of Care

Standard	Reference
PCP-to-member ratio.	Proposed BBA Rules, Sec. 438.306 (d)(1); QISMC 3.1.1.1

This standard was used explicitly or implicitly by all the states in the sample. Although all states use some form of this standard as a measure of network adequacy, performance measures differ. For example, the Arizona RFP specifies that, “*At a minimum the Contractor’s number of full-time equivalent PCPs to enrolled members shall not exceed a ratio of 1:1800 for adults and 1:1200 for children who are 12 or younger.*” (Section D.22) The Rhode Island contract specifies that, the “*Contractor agrees to assign no more than 1,500 RItE Care members to any single PCP in its network. For PCP teams and PCP sites, Contractor agrees to assign no more than 1,000 RItE Care members per single primary care provider within the team or site.*” (Section 2.08.02.06) The Texas

Dallas and El Paso request for applications (RFA) specifies that *‘The HMO must have at least one full-time equivalent PCP for every 2,000 Members and one full-time, board certified/board eligible pediatrician for every 2,500 Members less than age 21.’* (Section 5.1) Finally, the Minnesota RFP states that a *‘Plan must submit a description of its participation requirements, including specifications of the plan’s acceptable PCP/Member ratio.’* (Appendix A., VIII.2.c)

When asked to explain the basis for the PCP-to-member ratio, most identified either state or federal regulation as the source. However, some states like Connecticut had developed ratios that were based on actual program experience.

Other states questioned the utility of the PCP-to-member ratio standard, arguing that a simple physician-to-patient ratio was inadequate to measure the capacity, willingness or ability of a physician to accept new Medicaid members. These states have gone beyond the PCP-to-member ratio specified in their contract, either by including additional requirements aimed at addressing PCP capacity, or by using an ongoing process to measure it. For example, the Arizona RFP states that *‘If the PCP contracts with more than one AHCCCS health plan, the ratio (PCP to enrolled member) shall be adjusted by the Contractor to ensure the total number of AHCCCS members does not exceed the above ratio.’* (Section D.22)

Tennessee has established an ongoing assessment process that requires MCOs to submit a primary care network listing on a monthly basis indicating which PCPs are closed to new members. PCPs that no longer accept new members are excluded from the PCP count that is used to calculate the PCP-to-member ratio. If there are not enough PCPs accepting new members in an MCO’s network, the MCO is required to expand the network to meet the shortfall or enrollment of new members is suspended.

Standard	Reference
For each provider type, including primary care providers, determine the following: the number and percentage that serve Medicaid patients; and the number and percentage that accept new Medicaid patients.	HEDIS 3.0/1998

Seven of the ten states interviewed indicated that they use this standard, or a variation thereof. This standard was viewed by many states as a means for obtaining a more accurate number to use when measuring the PCP-to-member ratio.

Tennessee’s Contractor Risk Agreement states that *“There shall be sufficient number of primary care providers who accept new TennCare enrollees within each geographical location in which the plan has marketed so that each primary care provider has a reasonable case load.”* (Section 2-3, b.2) The Rhode Island Medicaid program’s RItE Care Contract states that the *‘Contractor agrees that all of its network providers will accept RItE Care members for treatment. Contractor agrees to have policies and procedures in place such that any provider in its network who refuses to accept a RItE*

Care member for treatment cannot accept non-RItE Care members and remain in the network.” (Section 2.08.02.06)

States that were not using the standard gave a variety of reasons for not doing so. In general they indicated that they did not use it because the requirements of other standards made it unnecessary. One state indicated that it did not use the standard because there is a state requirement that physicians that serve state employees must accept Medicaid patients, so most physicians accept Medicaid patients.

Although this standard was used widely, states indicated that it was not as useful when used alone as it was when combined with a PCP-to-member ratio standard. They also felt the ratio was more useful in conjunction with this standard.

Assessment Methods for PCP-to-member Ratio and Medicaid Capacity Standards

Assessing PCP-to-member ratio is reportedly straightforward and uncomplicated. States reported that counting the number of PCPs and members is relatively simple, and generating a report that gives the correct ratio is relatively uncomplicated.

However, determining the network’s capacity, which some consider a truer reflection of its ability to meet members’ demands, is much more difficult. In fact, while three states identified PCP-to-member ratio as one of the easiest measures to assess, four states identified the PCP capacity as one of the most difficult. The states that currently assess PCP capacity include any or all of the following in their measures:

- The status of the physician’s panel (i.e., open or closed);
- The total number of a physician’s Medicaid patients, across all plans; and,
- The total number of patients (commercial and non-commercial) across all contracts/payers.

Of those states who said that PCP capacity is difficult to determine, a common source of frustration is that it requires the collection of information beyond the population of Medicaid members for a particular plan or all plans, and extends into other lines of business. This means that tracking numbers of patients through state enrollment data may not be enough.

Participants reported using two methods to capture the capacity information:

- Physician surveys conducted by the state or the plan by phone, mail or site visits regarding the status of their panel and total patient census; and,
- State enrollment data tracking of the total number of Medicaid managed care patients by PCPs.

Example: The Agency for Health Care Administration in Florida requires plans to collect attestations from physicians on an annual basis. Physicians have to attest to the size of their patient panel, their appointment wait times, and whether they are accepting new patients. These attestations are used to hold physicians accountable for reporting accurate information.

Example: The Bureau of TennCare in Tennessee has taken the capacity determination a step further by requiring plans to determine capacity in specific service areas such as prenatal care. The plans are expected to determine prenatal care capacity by counting the number of physicians whose patient panel size falls below a certain number, who are accepting new patients, who accept patients with presumptive eligibility, and who provide prenatal care services. The State has recently undertaken a process whereby, it contacts each participating provider in each plan annually by phone and conducts a survey to verify the information provided by the plan.

The use of these methods is determined primarily by the state’s definition of capacity. If capacity is limited to Medicaid members, enrollment data can be used. However, if it includes the total patient census, the survey method has to be employed.

Some of the reported problems associated with these methods include:

- High costs associated with conducting physician surveys;
- Obtaining an accurate response from physicians;
- Developing a clear and concise definition of those patients that should be counted as part of the physician’s patient panel; and,
- Deciding on a patient census that is equitable and widely applicable.

Standard	Reference
Provider turnover by provider type (including primary care providers).	HEDIS 3.0/1998

This standard requires states or MCOs to track the entry and exit of providers from provider networks. This tracking may enable states to identify and solve potential problems early enough to avoid serious problems in provider services and network quality of care.

Seven of the ten states surveyed indicated that they do not use this standard in assessing network adequacy. Of these states, several reported they do not believe a standard regarding provider turnover by provider type would be very useful. However, all of these states indicated that they collect data on provider turnover and use this data in assessing network adequacy. For example, although California the Medi-Cal contract states, “*The Contractor will submit to DHS on a monthly basis, in a format specified by DHS, a report summarizing changes in the provider network.*” (Section 6.6.14)

Assessment Methods for Provider Turnover by Provider Type Standard

The states that use this standard reported that they track provider turnover through the following assessment methods:

- Various reports, including PCP network and capacity reports (MN, RI, TX); and,

- Annual or as needed on-site reviews of MCOs (RI).

Standard	Reference
MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands.	Proposed BBA Rules, Sec. 438.306 (d)(1); QISMC 3.1.6

The implied intent of this standard is to ensure that MCOs maintain networks adequate in number and mix over time.

Although all the states in the sample reported reviewing network adequacy periodically to assess their ongoing adequacy, eight of the ten states reported that they had a formal standard. For example, the Connecticut Medicaid program's contract states that "*On a monthly basis and through the methodologies described in the Network Methodology Document (Appendix C) the Department shall evaluate the adequacy of the MCO's provider network... Maximum Enrollment Levels. Based on the adequacy of the MCO's provider network the Department may establish a maximum Medicaid enrollment level for Medicaid recipients for the MCO on a county-specific basis...*" (Section 3.9)

Example: In Arizona, AHCCCS conducted a provider survey of PCPs and specialists regarding the adequacy of specialty networks. The survey was comprehensive and will be conducted bi-annually. They received a response rate of greater than 60% and were able to get a clear picture of the strengths and weaknesses of the specialty networks.

Iowa, a state that reported using the standard, bases its standard on geographic distribution by provider type and expected enrollment in a geographic location. Iowa assesses networks on a quarterly or as-needed basis, depending on the nature or volume of complaints. Rhode Island reviews its networks annually or on an as-needed basis.

Other states have promulgated much more specific standards and processes. For example, the Medi-Cal program's contract with Contra Costa Health Plan states that "*The Contractor will maintain a provider network adequate to serve 60% of the Eligible Beneficiaries in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the 60%. However, after the first twelve months of operation, if enrollments do not achieve 75% of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.*" (Section 6.6.2)

Assessment Method for Adjusting the Number and Distribution of Providers Standard

States reported using a wide variety of assessment methods for this standard. The method most often cited was tracking complaints. Four states (Connecticut, Minnesota, Rhode Island and Texas) indicated that problems of specialist shortages were brought to their attention by monitoring complaints. In a similar fashion, Minnesota works with county-level member advocates who report access problems to the state. Some of the other assessment methods include:

- On-site reviews (AZ, RI, TX);
- Staff and provider contract reviews (FL);
- Reports regarding numbers and types of providers (IA, RI); and,
- Descriptive analysis of MCO network adequacy oversight process (RI).

Standard	Reference
State standards regarding travel time and distance. MCO is in compliance with the state's standards regarding the maximum travel and distance times to PCPs and specialists. If no state standards, MCO has method for determining geographic access needs based on distance, travel times, and means of transportation.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISMC 3.1

Like the PCP-to-member ratio, this standard was used by all the states in the sample. The implied intent of this standard is to ensure that Medicaid recipients have access to medical practitioners who are located within reasonable distances and travel times. Both time and distance are important because there is a direct relationship between the proximity and convenience of a provider.

Although all the states reported using this standard, the performance measures differed and states were very flexible in its application. The most common performance measure was that all members must have access to a PCP who is within thirty miles or thirty minutes of travel time. For example, the TennCare contract states that *“Primary care providers shall be strategically located so that no enrollee shall be required to travel more than thirty (30) miles or thirty (30) minutes one-way, whichever is less, to a primary care provider.”* (Section 2-3. b) In Attachment IX of the same contract, Tennessee differentiates between rural and urban areas by maintaining the thirty miles, thirty minute standard for rural areas and adding a twenty miles or thirty minutes standard for urban areas.

Some states developed the travel time and distance standards for specific provider types, often changing the performance measures. For example, the Florida contract states that *“PCPs and hospital services must be available within 30 minutes typical traveling time, and specialty physicians and ancillary services must be within 60 minutes typical traveling time from the member’s residence.”* (Section B)

Arizona, California, and Texas, which have MCOs serving members in both urban and remote rural settings, developed performance measures that accommodate their unique circumstances. For example, Arizona developed travel time and distance performance measures that were unique to MCOs providing services to members residing in and around Phoenix and Tucson, the two major urban areas in the state. The Arizona AHCCCS RFP states that *“The proposed network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix and Tucson do not have to travel more than 5 miles to see a PCP or pharmacy. 95% of its members residing outside the boundary area must not have to travel more than 10 miles to see such providers.”* (Section D. 24) Texas and California use statewide standards, but also include the possibility of MCO-specific alternative performance measures. For example, the Texas Medicaid program’s Dallas and El Paso Service Area RFA states that *“The Applicant must ensure that primary care providers and general hospitals will be located no more than 30 miles from the residence of any Member, unless the contractor has a TDH-approved alternative distance standard.”* (Section 5.1) The contract between the Medi-Cal program and the Contra Costa Health Plan states that *“The Contractor will maintain a network of Primary Care Physicians which are located within 30 minutes or 10 miles of a Member’s residence unless the Contractor has a DHS-approved alternative time and distance standard.”* (Section 6.6.1)

Assessment Methods for Geographic Access Standard

Geographic access was cited most frequently by states as the easiest standard to assess. Assessment methods varied from state to state, depending on the nature of the standard, but geographic access is generally determined by plotting the location of providers’ offices to ascertain sufficient coverage over a specific geographic area. States reported tracking geographic access by the following methods:

- Mapping software packages (i.e., GeoAccess) (CA, DE, TX);
- Manually plotting on a map (MN);
- Establishing specific goals for numbers of physicians by geographic area and measuring MCO networks against them (RI); and,
- Driving distances from member residential areas to provider offices to verify the time/distance standards (FL).

While most respondents reported that it is relatively easy to track geographic access, they also reported that some problems arise with these methods, including:

- Incomplete or incorrect data files (MN, FL); and,
- Accurately measuring average travel times for members (FL).

One of the biggest frustrations identified by participants in using mapping software was incomplete or incorrect data files. If the addresses or zipcodes for providers and members

are incorrect, the software program will not produce an accurate reflection of geographic access.

Accurately estimating travel distance is difficult as well because it potentially involves several factors, including the layout of the public transportation system, traffic, and member car ownership. AHCA staff in Florida have driven routes that would have to be traveled by members to reach a provider to determine if an MCO is in compliance with the requirement. This method can prove particularly challenging in remote areas, and MCOs often seek waivers from the state or have to provide some form of transportation to members.

Rhode Island and Delaware, which are small states, are able to rely more heavily on staff knowledge of the geographic distribution of specific providers and travel conditions to determine whether the MCOs meet the geographic access standards.

Standard	Reference
MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services, and urgent care services.	Proposed BBA Rules, Sec. 438.306 (d)(5) & (6); QISMC 3.1.3 & 3.1.4

The implied intent of this standard is to ensure that Medicaid members have access to urgent care services and emergency services 24 hours a day, seven days a week.

The language used in the individual state standards varied greatly, ranging from very detailed to far less so. For example, the Minnesota contract and RFP states that *“The health plan shall make available to enrollees access to medical emergency services, post-stabilization care services and urgent care on a 24-hour, seven day per week basis. The health plan must provide a 24-hour, seven day per week health plan telephone number that is answered in-person by the health plan or an agent of the health plan; this telephone number must be provided to the state. The health plan is not required to have a dedicated telephone line.”* (Section 6.14) / *As described in Minnesota Rules, section 4695.1010, each health plan must make primary care physician services available 24 hours per day, seven days a week within the area served by the health plan. In addition, a 24-hour toll-free number must be available for MA/GAMC/MinnesotaCare enrollees.”* (Section VII.A.4)

The RIte Care contract states that *“Pursuant to 42CFR 434.30, Contractor agrees to provide emergency services which are available twenty-four hours a day and seven days a week, either in Contractor's own facilities or through arrangement, with other providers. Contractor agrees that services shall be made available immediately for an emergent medical condition including a mental health or substance abuse condition.”* (Section 2.09.01) / *“Contractor also agrees to have written policies and procedures describing how members and providers can contact it to receive instructions or prior authorization for treatment of an emergent or urgent medical problem.”* (Section 2.09.03) Finally, the Arizona RFP states that *“There shall be sufficient professional and*

paramedical personnel for the provision of covered services, including emergency medical care on a 24-hour-a-day, 7-days-a-week basis.” (Section D. 24)

Assessment Methods for 24 Hours/7 Days a Week Access Standard

Most states reported using more than one assessment method for this standard. The large number of methods can be grouped in three categories: *member feedback*, *direct provider contact*, and *qualitative review*.

The assessment methods rely heavily on *member feedback*. Four states reported tracking complaints as an assessment method, and two states (Delaware and Rhode Island) identify member surveys as assessment methods. *Direct provider contact* ranks second, with three states (Iowa, Texas, and Delaware) utilizing random after-hour calls, and one state (Texas) which uses a provider survey.

The third category, *qualitative review*, consists of several different activities. Three states reported using an on-site review process to look at materials including contracts, policies and procedures, and handbooks. Two states (Florida and Texas) reported using quality improvement-related activities, such as focused studies, to assess performance in this area. Two other states (Minnesota and Rhode Island) require MCOs to submit descriptions of their processes, which is then evaluated by the state.

Standard	Reference
MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	Proposed BBA Rules, Sec. 438.306 (d)(6); QISMC 3.1.4

The implied intent of this is to ensure access to care for members, such as those with jobs, who might have difficulty accessing care during normal business hours.

One state in the sample (California) indicated that it employed this standard. This is demonstrated through the contract language which states that ‘*At a minimum, Contractor shall ensure that a physician or a Nurse under his (her) supervision will be available for after hours calls.*’ (Section 6.5.7.7)

There were a variety of opinions about this standard. Several states that did not use this standard indicated they thought it may be useful for reducing unnecessary emergency room use. Others thought office hours should not be dictated by the state and should instead be left to community standards. Still others thought the standard unrealistic, stating that it would place a heavy burden on states and MCOs.

Assessment Methods for Evening and Weekend Hours Standard

Only two of the states in the sample require MCOs to have providers who offer evening or weekend office hours. However, several reported using different methods to assess whether the hours of operation are convenient and meet members’ needs. These methods include:

- Monitoring complaints (CT);
- Conducting member surveys (TX);
- Reviewing clinic hours submitted by the plans (MN);
- Random phone calls to provider offices (CA, CT); and,
- Conducting audits/on-site reviews of offices (CA, TX).

Standard	Reference
State standards regarding appointment waiting times. MCO is in compliance with the state's standards regarding appointment waiting times. If no state standards, MCO has method for determining and tracking appointment waiting times.	Proposed BBA Rules, Sec. 438.306 (e)(1)(I); QISMC 3.1.7.1; HEDIS 3.0/1998

The implied intent of this standard is to ensure that members are able to receive care within reasonable timeframes.

All of the states in the sample used some variation of this standard to assess network adequacy. There was wide variation in the specifics of the standards and in the performance measures used by states. Most states' standards included appointment waiting times for emergency, urgent, and routine care. For example, the Delaware RFP states that *"The MCO shall have procedures in place that ensure... (b) Emergency primary care appointments are available the same day, (c) Urgent care PCP appointments are available within 2 calendar days, (d) Routine care appointments are available within 3 weeks of member request..." (Section 9.3)*

Other states went well beyond emergency, urgent, and routine care and included standards for a variety of other services such as prenatal care, dental services, wellness care, and transportation services. The Arizona AHCCCS program's RFP addresses emergency, urgent, and routine visit appointment waiting times and goes on to address appointment waiting times for other services *"...maternity care, first trimester – within 14 days, second trimester – within 7 days, third trimester – within 3 days...routine behavioral health screening – within 7 days of referral..." (Section D. 19)*

One state (Minnesota) elected not to use specific performance measures, stating instead in its contract with MCOs that *"The health plan must develop a process for monitoring the scheduling of appointments along with the actual time which enrollees must wait to be seen at the office or clinic. When excessive, the plan should take appropriate action."* (Section 7.4)

Several states included standards for in-office waiting times. The Delaware RFP states that *"Members with appointments shall not routinely be made to wait for more than one hour."* (Section 9.4) The TennCare contract states that *"Waiting times shall not exceed 45 minutes."* (Attachment IX)

Assessment Methods for Appointment Waiting Times Standard

One state indicated that tracking appointment availability and waiting times is one of the most difficult standards to assess. States reported that it is difficult to measure these indicators accurately because they require soliciting information from PCP staff, for whom there is a disincentive to respond truthfully where there is a problem. The assessment methods employed include:

- Phone surveys of physicians, in which the state or plan official self-identifies (MN);
- Phone surveys of physicians, in which the state or plan official does not self-identify (MN);
- On-site reviews of appointment books and observations of waiting room traffic (AZ, FL, RI);
- Member surveys (DE, TX); and,
- Member complaints (CA, CT, DE).

Example: One challenge in assessing compliance with this standard, identified by CalOPTIMA, is that some physicians maintain more than one office and the offices are often in different geographic areas. It is possible that the physician may meet the appointment timeliness standards, but may violate the time/distance access standard. For example, a physician may be able to see a member within twenty-four hours for an urgent care visit yet, may not be available at the office closest to the member.

Some of the reported problems associated with these methods include:

- Inaccurate information reported by PCP staff;
- Questioning PCP staff without self-identifying engenders distrust and anger from PCPs and their staff; and,
- On-site reviews are sporadic and often announced, so they may not provide an accurate reflection of performance.

Given these problems with the assessment methods, member feedback was identified as one of the most effective ways to identify providers or MCOs that are in violation of an appointment timeliness or in-office waiting time standard.

Standard	Reference
MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	Proposed BBA Rules, Sec. 438.306 (e)(1); QISMC 3.1.7.1

The implied intent of this standard is to ensure that MCOs disseminate information about appointment timeliness standards and have processes in place to comply.

Six of the ten states in the sample indicated that they used this standard to assess the adequacy of the networks of MCOs in their state. In general, the states in the sample acknowledged that this was a useful standard. Some of the states that did have such a

standard include explicit requirements. For example, the Arizona AHCCCS contract states that *“The Contractor shall have written policies and procedures about educating its provider network about appointment time requirements. The Contractor must assign a specific staff member or unit within its organization to monitor compliance with appointment waiting time standards and shall require a corrective action plan when appointment standards are not met. /At a minimum, the Contractor’s provider manual must contain information on the following... AHCCCS appointment standards.”* (Section D. 21) The Delaware Medicaid program’s RFP states that *“The MCO must have established written procedures for disseminating its appointment standards to the network and must assign a specific member of its organization to ensure compliance with these standards by the network...The MCO shall have written policies and procedures concerning how the MCO educates its provider network and about appointment time requirements.”* (Section 9.5)

Assessment Methods for Communicating Timeliness Standard

In general, states did not place much emphasis on assessing this standard. Several assumed that requiring plans to adhere to timeliness standards is sufficient and leave the communication of the standards to the plans’ discretion. The assessment methods used by states that do assess this standard include:

- On-site reviews/audits including reviews of contracts, policies and procedures, correspondence, and conducting interviews (AZ, MN, CA, CT, RI);
- Tracking complaints (IA); and,
- Review of provider manuals (TX).

Standard	Reference
The percentage of enrollees aged 20-44, 45-64, and 65 who had an ambulatory or preventive care encounter during the reporting year. Inpatient procedures, hospitalization, emergency room visits, mental health and chemical dependency are excluded.	HEDIS 3.0/1998

The implied intent of this standard is to ensure that MCOs take affirmative steps to provide and track primary and preventive care to members.

Although only five of the ten states in the sample reported using the standard, all noted that they required MCOs to report encounter data.

Some of the states that reported using this standard, or a variation of this standard, include specific language in their contract. For example, California’s Medi-Cal contract with the Contra Costa Health Plan requires that *“The Contractor will develop, implement, and maintain procedures for the performance of initial health assessment for each Member within 120 days of enrollment.”* (Section 6.5.10.2) The Rhode Island contract requires that the *“...Contractor agrees to provide, for each member, a person-level record that describes the care received by that individual during the previous quarterly*

period. In addition, Contractor agrees to provide aggregate utilization data for all members at such intervals as required by the State./ New adult members are offered a first visit with a PCP within 6 weeks of enrollment.” (Section 2.13.02; Attachment M)

The states that did report using such a standard reported they were able to obtain the data they need to assess plan performance in this area through other standards. For example, the Minnesota Medicaid program requires in its contract with MCOs that *“The health plan must maintain patient encounter data to identify the physician who delivers services to enrollees, as required by Section 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. Section 1396b(m)(2)(A)(xi).” (Section 3.5.1)*

Assessment Methods for Ambulatory and Preventive Care Encounter Standard

The methods used to assess performance in relation to this standard include:

- Encounter data (DE, MN); and,
- Utilization data (CA, TX).

Standard	Reference
MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventive services.	Proposed BBA Rules, Sec. 438.306 (d)(2); QISMC 3.1.1.2

The implied intent of this standard is to ensure that women do not encounter barriers in seeking women’s health services, including, but not limited to, pregnancy detection and prenatal care services.

Seven of the ten states in the sample indicated that they use this standard in assessing the adequacy of provider networks. These states reported doing so several ways, ranging, from allowing direct access to a women’s health specialist if the PCP selected is not such a specialist, to allowing direct access to a specialist only if the specialist is selected as a PCP. For example, the Texas Medicaid program allows direct, unimpeded access to both PCPs and a women’s specialist. The Texas RFA states that a *“Contractor must allow a female Member to select, in addition to a PCP, an OB/GYN to provide health care services within the scope of the professional specialty practice of a properly credentialed OB/GYN, in accordance with Article 21.53D of the Texas Insurance Code. The Member who selects an OB/GYN may have direct access to the health care services of the OB/GYN without a referral by the woman’s PCP or precertification from the Contractor.” (Section 5.1)*

Florida, one of the states that indicated it allows women direct access to a women’s health specialist, reported doing so only if the member selected an OB/GYN as a primary care physician.

Although Arizona and Iowa indicated they did not use this standard in assessing provider networks, both indicated that prompt access to women’s services is an important goal that

could be achieved through other means. Iowa, for example, includes requirements in its contract that address the issue in another manner (i.e. through family planning services) Its Medicaid contract with MCOs states that *“HMO shall give each enrollee, including adolescents, the opportunity to use his or her own primary physician or go to any family planning center for birth control, pregnancy testing or reproductive health services without requiring a referral.” (Section 4.2.3.2)*

Assessment Methods for Direct Access Standard

The assessment method most frequently used for this standard is tracking member complaints, reportedly used by four of the six states that provided assessment methods for it. Additional assessment methods are as follows:

- Annual audits of claims data (CA); and,
- Annual site visits (RI).

Standard	Reference
The MCO identifies providers whose facilities are accessible to people with disabilities.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISMC 3.5.1.1

The implied intent of this standard is to ensure that members who are mobility-impaired are guaranteed physical access to services in MCO networks.

Nine of the ten states in the sample indicated that they used such a standard in assessing the adequacy of MCO provider networks. Several of the states use very precise language in their contracts. For example, the Rhode Island Medicaid program contract indicates that the *“Contractor agrees to conform with standards outlined in the Americans with Disabilities Act for purposes of communicating with and providing accessible services to its visually and hearing impaired, and physically disabled members./ In addition a [provider network] list shall be provided quarterly that includes designation of language capability of the provider and physical accessibility of the provider's location, as well as applicable addresses and telephone numbers.” (Sections 2.06.02.04 and 2.08.12)* The Connecticut Medicaid program’s contract states that *“The MCO shall have systems in place to ensure access to medically necessary and medically appropriate well-care by its Members. The MCO shall develop procedures to identify access problems and shall take corrective action as problems are identified. These systems and initiatives shall include but not be limited to: ...6. Assistance to disabled Members in accessing and locating services and providers that can appropriately accommodate their needs, for example wheelchair access to provider's office; ... b) The MCO's access systems will be assessed as part of the annual performance review of the MCO.” (Section 3.21)*

Assessment Methods for Accessible Facilities Standard

Identifying facilities that are accessible to people with disabilities is commonly part of the contracting or credentialing process. Therefore, states that assess related, MCO performance tend to do so through on-site or desk reviews of the MCO contracting

process, provider files, provider directories, and related policies and procedures. Two states, Connecticut and Delaware, assess this standard through member complaints, and one state, Florida, conducts its own on-site review of provider sites.

Standard	Reference
The number of Perinatal Care Level II and Level III facilities in the provider network. The MCO has procedures in place to direct providers to the facilities.	HEDIS 3.0/1998

The implied intent of this standard is to ensure that adequate resources for children requiring technology-intensive care are available for members in MCO networks.

Although only six of the ten states in the sample indicated that they used this standard to assess the adequacy of provider networks, almost all said that access to these services was not an issue in their state. The states that reported using such a standard included very specific language in their contracts. The Florida Medicaid program includes in its contract a statement that *“Plan must assure access for patients to Florida Regional Perinatal Intensive Care Centers for Medically high-risk prenatal care, both prenatal and neonatal, and complex neonatal surgery.”* (Attachment 1.6.c) Iowa’s contract specifies that *“HMO shall have systems in place to ensure well managed patient care that is coordinated and continuous, including at a minimum linkages with state and public health officials to foster continuity of services, prevent cost shifting to other publicly funded programs and make reasonable efforts to assure collaboration with official entities responsible for essential core public health functions and systems to assure appropriate referral to duly authorized Regional Perinatal Centers for high risk maternity and neonatal medical care.”* (Section 4.7)

The states that indicated they did not employ such a standard tended to be those in which there was a limited number of Level II and Level III facilities and contracting with these facilities had not been a problem.

Assessment Methods for Perinatal Care Level II and Level III Facilities Standard

The assessment methods used for this standard include:

- Review of provider directories (CA, FL);
- On-site reviews of policies and procedures, provider agreements, other related documents (IA, RI); and,
- HMO provider panel submissions (IA, TX).

Standard	Reference
<p>Availability of translators in American Sign Language (ASL). MCO is in compliance with the state's standards regarding availability of translators in ASL. If no state standards, MCO has method for ensuring the availability of ASL translators.</p>	<p>STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53</p>

The implied intent of this standard is to ensure that hearing disabled members are not denied access to needed services because of the inability of MCO staff or providers to communicate with them.

All of the states in the sample recognized the importance of this requirement to access and quality, and all indicated that the issue of translators for hearing impaired members was addressed in their state. Nevertheless, only seven of the ten states in the sample indicated that they used this standard in assessing MCO provider network adequacy.

The reported standards ranged from the very specific, such as one used by the Texas Medicaid program, to the less specific such as the one used by Arizona and Minnesota. The Texas Medicaid program’s Dallas and El Paso RFA states *“The Contractor shall provide interpreter services for Members as necessary to ensure availability of effective communication regarding treatment, medical history or health education, in accordance with the Standards for Quality Improvement in Appendix A (Standard X, A-6-d) The Contractor must provide interpreters for face-to-face services for medical appointments in a provider’s office. The Contractor may request to TDH that an exception to this requirement be made on a case-by-case basis, if an alternative to face-to-face services is necessitated by individual circumstances.”* (Section 4.10.1) The Arizona contract states *“People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility.”* (Section E.32) The Minnesota contract states *“All membership materials must include the following statement, “If you ask we will give you this information in another form, such as Braille, large print, or on audio tape.”* (Section 6.15.12)

Those states that did not report having an explicit standard indicated that the matter was addressed effectively using other approaches, such as requiring that MCOs and the providers in their networks comply with the Americans with Disabilities Act and all related state legislation.

Assessment Methods for ASL Translator Standard

Assuring the availability of translators in American Sign Language is a standard that most of the states surveyed assess by monitoring complaints. The general approach is that if a member needs such services and the MCO is negligent in providing them services, this gap will surface through member complaints or through a member satisfaction survey, which is currently used by one state (Delaware). Two states (Texas and Rhode Island) review information materials to ascertain whether the availability of such services

is appropriately communicated to members. Some of the other assessment methods include:

- EQRO audits (CT);
- Reviews of RFP responses (MN); and,
- On-site reviews of referral mechanisms and staff interviews (RI, TX).

Standard	Reference
Availability of TDD services. MCO is in compliance with the state's standards regarding TDD services. If no state standards, MCO has method for ensuring the availability of TDD services.	STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53

The implied intent of this standard is to ensure that hearing-impaired members are guaranteed access to effective methods of communication.

Eight of the ten states in the sample indicated that they employed such a standard to assess the adequacy of the MCO provider networks. The Connecticut Medicaid program's contract states that *"The MCO shall also take appropriate measures to ensure access to services by persons with visual and hearing disabilities. Information concerning members with visual impairments and hearing disabilities will be made available through the daily and monthly EMS enrollment data...d. Sanction: For each instance of failure to provide appropriate linguistic accessibility to Members, the Department may impose a Class A sanction pursuant to section 7.4."* (Section 3.27) The Delaware RFP states that *"...all entities will have TDD communication services available."* (Section 5.4.6) The Texas Medicaid program's Dallas and El Paso RFA states that *"In addition, the Contractor must have capabilities to provide TDD access."* (Section 4.10.1)

Some of the states that reported that they did not have such a standard indicated that it is a federal requirement that is enforced by other state agencies.

Assessment Methods for TDD Services Standard

Because of the nature of TDD services and the equipment necessary to provide them the majority of states that reported using an assessment method for this standard indicated that they employ some kind of on-site review process to do so. As is the case with the assessment process for ASL translation services, two states use member complaints and one state uses a member survey to help uncover any problems in the provision of these services. Additional assessment methods include:

- EQRO studies (DE);
- Blind calls to the plan (TX); and,
- Review of the cultural competency plan (TX).

Standard	Reference
<p>State has process for ensuring the MCOs have relationships with public health, education, and social services agencies.</p>	<p>HEDIS 3.0/1998</p>

The implied intent of this standard is to ensure that MCOs establish relationships with traditional service providers in their communities.

All of the states in the sample indicated that this standard was used in their state to assess the effectiveness of MCO provider networks. Most states indicated that these agencies and traditional providers know the population and their needs well and are an excellent foundation for a Medicaid managed care network.

Although all states used this standard, the specificity of their individual requirements varied widely. For example, the Texas RFA states that *“The Contractor must make an effort to establish linkages with other programs such as Head Start, WIC, local health departments, etc. This linkage should provide a referral source and necessary communication with Member’s medical home or Primary Care Providers./ Applicant will submit copies of all binding LOIs or LOAs with TDH Regional offices and city or county health departments.”* (Section 6.3)

The Rhode Island Medicaid program’s RItE Care contract states that the *“Contractor shall establish processes to coordinate in-plan and other services delivery with services delivered outside of the Health Plan...Although such services are not RItE Care Health Plan covered benefits, the State expects that Contractor will promote and coordinate such services to avoid service fragmentation. [The list includes: special education, mental health services for special populations, Dept. of Children Youth and Families/Dept. of Health/Dept. of Human Services Special Programs.] /There are currently four school-based clinics in Rhode Island, located in ...Contractor is required to include these four school-based clinics in its network for delivery of RItE Care covered services available at the school-based clinics by the effective date of this Agreement.”* (Sections 2.07.01 and 2.08.10)

The Medi-Cal program’s contract with the Contra Costa Health Plan states that *“The Contractor will execute a Subcontract for the specified public health services with the Local Health Department (LHD) in each county that is covered by this Contract.”* (Section 6.7.8.1)

Assessment Methods for Ensuring Relationships Standard

The assessment method most often used for this standard is the on-site review or desk audit review of written documentation regarding an MCO’s relationship with public health, education, and social service agencies. Eight of the nine states that reported using an assessment method use a review of this nature. In addition to a contract review, one

state (Delaware) also conducts a survey of providers and state agencies to ascertain their level of involvement with the MCOs.

II. Network Quality

Standard	Reference
State evaluates MCOs credentialing and recredentialing process for all providers, including institutional providers.	HEDIS 3.0/1998; QISMC 3.1.2

The implied intent of this standard is to ensure that providers serving Medicaid recipients have credentials that help ensure high quality care.

All the Medicaid programs in the sample agreed that this standard was essential, and nine of the ten states indicated that they used this standard to assess the adequacy of the MCO provider network in their states. The state that indicated it did not use the standard (Delaware) did not do so because the credentialing and recredentialing processes of MCOs were evaluated by another state agency, the State Insurance Commission. The Delaware RFP states that *“The MCO must have written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to HCFA’s “A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States”, or subsequent revisions thereof.”* (Section 12.4)

The states that indicated that they did use this standard used equally explicit language. For example, the Florida Medicaid program’s contract states that *“The plan is responsible for assuring that all persons, whether they be employees, agents, subcontractors and/or anyone acting for or on behalf of the plan, are properly licensed under applicable state law and/or regulations and are eligible to participate in the Medicaid program. The plan shall credential and recredential all plan physicians and other providers. Hospital ancillary service providers are not required to be independently credentialed by the plan if those providers only provide services to the plan through the hospital. School-based service providers are not required to be credentialed by the plan if the plan can document that the school has signed one of the credentialing agreements.”* (Section I.B.5)

Assessment Methods for Credentialing/ Recredentialing Standard

The assessment method most often used for this standard is the review of policies and procedures, MCO records, credentialing files, and credentialing committee meeting minutes. This review is conducted as an on-site review or desk audit.

MCOs are often required to describe their credentialing and recredentialing process as part of their RFP response. States like Rhode Island, for example, analyze this response as part of the assessment process for this standard.

Standard	Reference
Percentage of providers who receive initial orientation to the plan and on-going training from the plan.	New Jersey Care 2000 HMO RFI Released for Public Comment, Volume I, NJ Dept. of Human Services, DMAHS, March 1998, page VI-3

The implied intent of this standard is to ensure that providers are given notice of the conditions participation and of their responsibilities to the MCO and its members.

Five of the ten states in the sample indicated that they used this standard in assessing the adequacy of MCO provider networks.

These states indicated that it is important to include explicit requirements for an initial orientation and for on-going contact between the MCO and providers regarding program changes. These requirements are expressed clearly in the Medi-Cal contract with the Contra Costa Health Plan which states that the *“Contractor will ensure that all providers receive training regarding the Medi-Cal Managed Care Program in order to operate in full compliance with the Contract and all applicable Federal and State regulations. Contractor will ensure that provider training relates to Medi-Cal Managed Care services, policies or procedures. Contractor will conduct training for all providers within 10 days after the Contractor places a newly contracted provider on active status. Contractor will ensure that ongoing training is conducted when deemed necessary by either the Contractor or the State.”* (Sections 6.6.19 and 6.6.20)

They are stated just as clearly in the Texas Medicaid program’s Dallas and El Paso RFA *“The Contractor will ensure that all providers receive training regarding the STAR Program in order to operate in full compliance with the contract and all applicable federal and state requirements. The Contractor will ensure that provider training relates to STAR Program services, policies, procedures and any modifications to existing services, policies or procedures; Member eligibility standards and benefits; Member enrollment/ disenrollment procedures; special needs of Members in general that affect access to and delivery of services to include, at a minimum, cultural sensitivity and linguistic information, the use of interpreter services and transportation, and the rights and responsibilities of Members. The Contractor will conduct training for all providers within 30 days after the Contractor places a newly contracted provider on an active status. The Contractor will ensure that ongoing training is conducted when deemed necessary by either the Contractor or TDH.”* (Section 5.1.3)

Although five of the states in the sample do not have an explicit standard that requires a provider orientation and ongoing training, many do collect this information and use it in their assessment. For example, Florida does not use such a standard but does collect information from providers on the training they have received from the MCO. The state indicated that it did not have such a standard because they considered initial provider orientation and ongoing training as activities that are routinely undertaken by MCOs making a standard unnecessary.

Assessment Methods for Orientation and Training Standard

The assessment method most often employed for this standard is a review of health plan documentation, including minutes of training sessions, provider contracts, and provider manuals. Through these reviews, states attempt to ascertain the number of providers receiving orientation and other training, and the level of MCO activity around providing training opportunities to providers.

In addition to conducting a review, two states (California and Rhode Island) also track provider complaints as a method for assessing performance in relation to this standard.

Standard	Reference
MCO has procedures in place to timely identify and furnish care to pregnant women.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.2

The implied intent of this standard is to ensure that pregnant women are identified early in their pregnancy by the MCOs and provided prenatal care. The states in the sample were unanimous in indicating that they used such a standard in assessing network adequacy and in recognizing the importance of the standard.

The language used in the standards tends to be explicit. For example, the Connecticut standard, which is included in the Connecticut Medicaid program's contract, states *"In order to promote healthy birth outcomes, the MCO shall: Identify enrolled pregnant women as early as possible in the pregnancy...b. Performance Measure: Early access to prenatal care: Percentage of women with live births who were enrolled during the first trimester of pregnancy who had a first prenatal visit prior to 13 weeks gestation from last menstrual period."* (Section 3.19) The Minnesota standard, which is included in the Minnesota RFP, states that *"Plan must describe how it will provide prenatal care services including a tracking mechanism for identifying individuals who are pregnant when they enroll and individuals who become pregnant after they enroll."* (Appendix A, VI.5)

Assessment Methods for the Timely Identification and Provision of Care to Pregnant Women Standard

The timely identification and provision of care to pregnant women requires that MCO's have a sound process or mechanism in place to do so. The assessment methods identified by states in this area included the following:

- Chart reviews (MN);
- On-site reviews (AZ, FL, RI);
- HEDIS audits and EQRO studies (CT, DE);
- Member grievances (CA, DE);
- Member surveys (CA,DE); and,
- Focused studies of pregnancy outcomes (MN,TX).

The challenge in assessing compliance with this standard has less to do with identifying appropriate care than it does the timely identification of pregnant women. Several plans indicated that they have struggled with innovative ways to ensure that women who are pregnant or suspect that they may be, get in touch with their provider or with the plan early on. These include providing information in the member handbooks, and conducting other forms of member outreach. Quite a few participants identified the timeliness component as a problem area.

Standard	Reference
MCO has procedures in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.3

The implied intent of this standard is to ensure that members with complex and serious medical conditions are identified early and their treatment needs attended to.

Eight of the ten states in the sample indicated that they used this standard in assessing the adequacy of the MCO provider networks.

The Delaware RFP contains the following language: *“Health plans will have in place all of the following to meet their [children with special health care needs] needs: (a) Satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist referrals, durable medical equipment, medical supplies, home health services, etc., (d) Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best interest of the member.” (Section 6.2.1)*

The Minnesota RFP contains the following language: *“Plan must describe its strategy for providing specialized services to individual who are developmentally disabled, physically handicapped, or chronically ill.” (Appendix A, VI. 8)*

Iowa, one of the states that does not use this standard, provided two reasons. First, its current Medicaid managed care program does not currently enroll SSI members. The state also indicated that when the program is expanded to include SSI enrollees, the state indicated it would consider adding this standard. Second, the MCOs currently survey all new members in an attempt to identify any serious health problems. If problems are identified, the MCOs place the member under case management and develop an appropriate plan of care.

Assessment Methods for the Timely Identification and Provision of Care to Individuals with Complex and Serious Medical Conditions Standard

The ability to identify and provide care to people with chronic and complex conditions in a timely manner requires that the MCO have a sound process or mechanism in place to do

so. The assessment methods identified for people with chronic and complex conditions included the following:

- Utilization reviews (CA);
- On-site reviews (AZ, FL, RI); and,
- EQRO studies/audits (CT, DE).

As with the previous standard regarding pregnant women, these methods focus more on whether members are receiving appropriate care than on their initial identification in a timely manner.

Standard	Reference
MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	QISMC 3.1.1.1 & 3.1.1.2

The implied intent of this standard is to ensure that members identified as having complex and serious medical conditions are assigned to care managers to assist in the coordination of their care.

Although this standard is related to the previous standard, which eight states indicated using, only five states indicated using this standard. The states that reported they had not adopted it provided a number of reasons. Delaware considered it unnecessary because not all disabled members need a care manager. Minnesota concurred, adding that blanket requirements added cost.

The states that did use this standard included specific requirements in their contracts. However, they did not believe that they bound them to provide care management services to members who did not need them. For example, the Connecticut Medicaid program's contract requires "...development of special initiatives, case management, care coordination, and outreach to Members with special or multiple medical needs, for example persons with AIDS or HIV infected individuals." (Section 3.21) However, they did not believe that this language requires the provision of unnecessary care management services.

Assessment Methods for Care Manager Standard

Only four of the five states that reported using this standard reported using assessment methods. Of the methods reported, two states (Texas and Florida) reported using a review process consisting of desk audits or on-site reviews of policies and procedures, contracts, and written quality improvement plans.

Two states (California and Florida) conduct reviews of utilization and claims data to check for assignments to care management.

III. Cultural Competence

Standard	Reference
MCO has process for identifying significant sub-populations within the enrolled population that may experience special barriers in accessing health services, such as the homeless or certain ethnic groups.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5

The implied intent of this standard is to ensure that significant sub-populations with special access issues are identified by MCOs so that their issues can be recognized and addressed.

Five of the ten states in the sample indicated that they used such a standard in assessing the adequacy of MCO networks, yet all states indicated that they recognized its importance. Some of the states that reported not using the standard said its intent was covered adequately by their more general requirement that MCOs address the needs of special populations. Others responded that they had not adopted such a standard because of the difficulties entailed in identifying some of the specified populations, such as the homeless.

The language used by states that had adopted the standard tended to be less specific than that used in other standards, perhaps reflecting the broadness of the issues involved. For example, the Delaware Medicaid program’s RFP states that “*..This [member] Advocate will participate in local community organizations to acquire knowledge and insight regarding the special health care needs of members.*” (Section 5.9) The Minnesota RFP states that the “*Health plan assures that it will work with each county in its contracted area to identify the community resources which specialize in the needs of minority groups.*” (Appendix A. VII. C) The Rite Care contract states “*Specifically, Contractor agrees to: identify and resolve member barriers to preventive care (such as language or transportation)...these policies and procedures shall take into account the unique characteristics of Rite Care members.*” (Section 2.06.02.03)

The Texas Medicaid program does not have a standard that addresses solely this issue. Instead its standard requires that MCOs conduct a community needs assessment that includes identifying special needs populations and develop a cultural competency plan that includes a plan for identifying special populations and their needs.

Assessment Methods for Sub-populations Standard

Each of the five states that reported requiring MCOs to have a process to identify significant sub-populations, uses a different assessment method. They are as follows:

- Review of the minutes of the MCO committee charged with this responsibility (CA);
- On-site reviews, including policies and procedures, and interviews with staff about process (FL);

- Contract manager direct contact with MCO administrators (MN);
- Special studies of the population (RI); and,
- Group needs assessment conducted by MCO (TX).

The nature of this standard is such that assessment methods review processes more than outcomes. Identifying ways to decrease access barriers for certain subgroups is a challenging task. In California, the plans have committees responsible for addressing this issue and the state assesses their process through the review of committee meeting minutes. In Florida, this issue is part of the on-site review process with plans. Minnesota relies on contract manager contact with the MCOs to gauge MCO success in this area. In Rhode Island, the state conducts periodic focused studies on which it relies to uncover problem areas.

Texas has a group needs assessment requirement as part of its contract with MCOs. MCOs are expected to conduct a comprehensive assessment of the health needs of their current and expected members to identify and limit potential barriers to care.

Standard	Reference
Ratio of providers who speak a language other than English to the number of Medicaid recipients (total recipients , not just MCO members) who speak the same language.	QISMC 3.1.5

The implied intent of this standard is to ensure that there are a sufficient number of providers who speak the languages of members whose primary language is not English.

None of the states in the sample indicated that they used this standard in assessing provider network adequacy. However, many of the respondents reported understanding the importance of including bilingual providers in networks, and indicated that they required that MCO networks include traditional providers who have historically served these populations. Some states went even further, including other requirements related to this standard. The Rhode Island Medicaid program, for example, requires in its RIte Care contract that *“a [provider network] list shall be provided quarterly that includes designation of language capability of the provider and physical accessibility of the provider’s location, as well as applicable addresses and telephone number.” (Section 2.08.12)*

Despite acknowledging the importance of including bilingual providers in provider networks, states did not think the standard was useful or practical. They did not think it was useful because they doubted the utility of simple ratios, which reveal nothing about the members’ need for bilingual services, nor do they ascertain the providers’ ability or willingness to use their language skills in their practice. States also considered the standard impractical because the cost associated with implementing it would be excessive and there was no valid means to measure compliance.

Assessment Methods for Bilingual Providers Standard

None of the participants maintained a specific ratio of providers but, for the most part, providers who speak languages other than English are identified and tracked by MCOs. They avail themselves of the following methods to assess whether the needs of non-English speaking members are being met:

- Complaints (CT);
- Annual site visit (review of staff, documents, provider directories, distribution of non-English speaking members) (CA,RI);
- Review of provider panel (TX); and,
- Readiness review (TX).

Standard	Reference
MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and arrangements for interpreter services.	Medicaid HEDIS 2.0/2.5

The implied intent of this standard is to ensure that members who are not proficient in English can access the MCOs’, and the networks’ services, even if providers who speak the members’ primary language are not available.

Most of the states in the sample indicated they saw the wisdom in such a standard, and nine of the ten states used this standard in assessing the adequacy of provider networks. Performance measures varied greatly, however. For example, the Connecticut Medicaid program’s contract requires that *‘The MCO’s Member services department shall include bilingual staff (Spanish and English) and translation services for non-English speaking Members. The MCO shall also make available translation services at provider sites either directly or through a contractual obligation with the service provider.’* (Sections 3.27 and 3.28) The AHCCCS RFP, contains less detailed performance measures, yet presents an equally clear standard, stating that *“Information shall be provided in English and a second language when 200 members or 5% of the Contractor’s enrolled population, whichever is greater, are non-English speaking. (AHCCCS will advise the Contractor when and if this requirement applies)”* (Section D.8)

The one state in the sample that indicated that it did not use this standard (Florida) does include clear requirements for interpreter services in its contract with MCOs. The Florida Medicaid program’s contract states that *“The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Threshold language is 5% of a population in a county.”* (Attachment I.B.11.b)

Assessment Methods for Bilingual Capacity Standard

An MCO’s capacity to communicate with its non-English speaking membership can be measured in a variety of ways.

None of the states had set ratios or requirements for numbers of bilingual staff. However, they planned to be sensitive to the issue and their assessment methods consisted of:

- On-site and operational reviews (AZ, DE, TX); and,
- Annual report submitted to state (MN).

Standard	Reference
MCO offers cultural competency training that educates providers about the medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5

The implied intent of this standard is to ensure that providers serving populations that have cultural beliefs or practices that may affect their health, or their response to health care, are aware of these beliefs and practices.

Three of the ten states indicated that they used this standard to assess the adequacy of provider networks. The Texas Medicaid program requirements are quite specific, including a requirement for a cultural competency plan covering training, performance standards and requirements, and a monitoring mechanism. The specific requirement, which appears in the Dallas and El Paso RFA, states that *“Contractor must develop and maintain a written Linguistic Services and Cultural Competency Plan describing how the Contractor will ensure that linguistically and culturally competent services are provided in a comprehensive and coordinated manner to Members...The Linguistic Services and Cultural Competency Plan must include...how the Contractor will educate its staff on linguistic and cultural needs and the characteristic of its Members; Implement the plan in its organization...for carrying out all portions of the Linguistic Services and Cultural Competency Plan; Develop standards and performance requirements of the delivery of linguistic services and culturally competent care, and monitor adherence with those standards and requirements.”* (Section 4.10)

Some states that did not use this standard explicitly did address the issue in other forms. For example, the Indiana Medicaid program’s RFP requires that *“Each MCO must describe how its proposed provider network will respond to the cultural, racial and linguistic needs of the Medicaid population.”* (Section 4)/ *PMPs and other network providers should have a comprehensive system in place to handle enrollee’s needs pertaining to language, cultural issues and disabilities.”* (Section 6)

Other states, like Minnesota, relied on a more market-based solution, choosing instead to require that MCOs include providers who were already familiar with the special populations' cultural issues. The Minnesota RFP requires that *“The health plan must offer appropriate services for the following groups...cultural and racial minorities-culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various cultural and racial minority groups; lesbian and gay men- sensitivity to critical social and family issues unique to lesbians and gay men. The plan must describe how it will provide culturally competent services. Must provide a complete list of the network's physician's (including mental health/chemical dependency providers) with special expertise in serving minority individuals.”* (Section 6.15.5 and Appendix a. VII.7)

Some states thought the standard impractical, citing the potential cost of such training and the difficulty in monitoring performance. One state said such training had been made available but was so poorly attended it had been dropped. Finally, one state that did not use the standard indicated that, due to the relative homogeneity of the state's population, there were no real efforts being made to address cultural issues.

Assessment Methods for Cultural Competency Training Standard

Given some of the difficulties associated with clearly defining cultural competence, there is a corresponding difficulty in developing assessment methods that accurately measure a plan's level of cultural competence. Some states did provide the methods that they use to measure the cultural competency of an MCO. These included:

- Review by committee (CA);
- Contract meetings (MN);
- Review of the plan's description of its process for oversight (RI); and,
- Review of the plan's cultural competency plan through the readiness review process (TX).

PERFORMANCE STANDARDS: MANAGED CARE ORGANIZATIONS

Like the states, the MCOs in the sample participated in the interviews and, with the exception of one, responded to the survey. Since states have established standards, it is understandable that all of the MCOs in the sample used the standards to some degree as part of their process for assessing network adequacy. However, the approach the MCOs took differed from those taken by the states, as did the rationale the MCOs gave for using them.

Performance Standards

The study revealed that:

- MCOs were already using some or all of the standards in assessing the adequacy of their networks;
- Some standards were more universally used than others. For example, as in the case of the states, the standards grouped under the heading of “Access to or Availability of Care” were used by most MCOs as part of their assessment process, while those grouped under “Cultural Competence” were used less often;
- The methods and measures used by MCOs tended to change, becoming more complex and detailed as MCOs matured;
- The measures used by MCOs to assess network adequacy were in some instances more stringent than those used by the states, indicating that their reasons for adopting and actively enforcing the standards went beyond the fact that they were required;
- The measures of network adequacy considered to be most important by MCOs differed from those considered to be most important to states; and,
- MCOs, particularly those operating plans in several states, were more likely to have gone beyond state standards when they found the standards to be inadequate for their purposes.

Assessment Methods

In response to the protocol and survey questions regarding assessment methods, the MCOs reported two types of activities: those that are used to measure performance in relation to the standards and those that are used to maintain compliance with the standards. The type of response varied depending on the nature of the standard. For example, when the standard referenced state activity (i.e., “State evaluates MCOs credentialing and recredentialing process for all providers, including institutional providers”), the MCO’s responses addressed how they maintain compliance with the state’s standard because their performance in relation to this standard is not applicable.

Standard Summary

To illustrate the specific findings of the standards and assessment methods the MCOs in the sample are using to assess network adequacy, the following section groups the standards under the three previously mentioned headings and describes how the MCOs are assessing each.

I. Access to or Availability of Care

Standard	Reference
PCP-to-member ratio.	Proposed BBA Rules, Sec. 438.306 (d)(1); QISMC 3.1.1.1

All MCOs indicated that they used this standard to assess the adequacy of their networks, primarily because it is a standard set by the state. However, most MCOs in the sample have gone beyond the PCP-to-member ratio and also identify those providers who accept new Medicaid patients. Managed Health Services responded that the PCP-to-member ratio combined with a determination of the number and percentage of PCPs who accept new Medicaid patients was a much more effective measure of PCP capacity than just the PCP-to-member ratio. Both of the health insuring organizations (HIOs) in the survey, CalOPTIMA and Contra Costa Health Plan, use a similar approach to create a performance measure for this standard, combining the PCP-to-member ratio data with data on PCPs accepting new Medicaid patients.

Standard	Reference
For each provider type, including primary care providers, determine the following: the number and percentage that serve Medicaid patients; and the number and percentage that accept new Medicaid patients.	HEDIS 3.0/1998

Six of the sampled MCOs indicated that they use this standard and thought it should be combined with the PCP-to-member ratio standard because both information sets were needed for decision making.

Two of the MCOs that reported not using the standard indicated that their decision was due to their serving only Medicaid members. They therefore thought the standard was irrelevant to their circumstances. Another MCO, Managed Health Services, which does not use this standard either, nevertheless thought it would yield useful information.

Assessment Methods for PCP-to-member Ratio and Medicaid Capacity Standards

Three plans, AmeriHealth, Contra Costa, and Managed Health Services, identified PCP-to-member ratio as one of the easiest areas to assess overall.

Several methods were used to determine the PCP-to-member ratio reported by plans, including:

- Member and provider data files (AmeriGroup, Contra Costa);
- Tracking the number of members per PCP panel (AmeriHealth, Prime Health);
- Provider affidavits (Humana PCA);
- Monthly visits by PR field reps (Xantus); and,
- Monitoring through GeoAccess reports (Xantus).

Several plans indicated that while the PCP-to-member ratio is a relatively easy standard to assess, a much more meaningful standard is one that measures PCP capacity. One MCO reported that measuring capacity is one of the most challenging standards to assess overall. The methods that MCOs use to measure capacity include:

- Tracking providers who are accepting new patients through provider files (AmeriGroup, Contra Costa);
- Tracking member complaints regarding access (Prime Health); and,
- Monthly visits by provider relations field representatives (Xantus).

Standard	Reference
Provider turnover by provider type (including primary care providers).	HEDIS 3.0/1998

Four of the MCOs in the sample reported using this standard to assess the quality of their provider networks. However five of the remaining six MCOs reported collecting the data in some form and using it to assess their networks.

For example, AmeriHealth reported that even though they did not use the standard as stated, they do collect and use PCP turnover data. These data provide an indicator of potential problems more than a standard of adequacy. Other MCOs that reported using provider turnover data noted that they found the information more useful as a quality measure than to measure network adequacy.

The MCO that reported not using the standard as stated, or any variation thereof, cited the difficulty involved in tracking the information with their manual system.

Assessment Methods for Provider Turnover by Provider Type Standard

Most of the plans surveyed indicated that they track provider terminations on an on-going basis but do not do so through a systematic reporting system. They pay attention to the issue because it can be a symptom of a larger problem in provider quality or provider relations. Their tracking is often conducted through the provider relations department. Only one plan (Humana PCA) stated that it was part of a regular, quarterly reporting and assessment process.

Standard	Reference
MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands.	Proposed BBA Rules, Sec. 438.306 (d)(1); QISMC 3.1.6

Six of the ten MCOs in the sample reported using this standard. All of the MCOs, even those that have not adopted it reported that they thought the standard important. However several MCOs also reported that it is difficult to assess. Humana PCA, for example,

noted that it has a full time person working on this matter, but that it remains a challenge because the situation is constantly changing. Many of the MCOs reported that they thought the information generated through the use of this standard was most useful when linked to the PCP-to-member ratio and the provider capacity standard.

One of the MCOs operating in a mature managed care market reported not currently using the standard but indicated that it was developing an internal process to measure provider turnover. It reported that it thought the information that would be yielded by such a process would be important for their efforts to “right-size” their network.

Assessment Methods for Adjusting the Number and Distribution of Providers Standard

Most of the MCOs interviewed indicated that they have a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties. The assessment methods reported were based on several of the other standards in this section, including:

- Tracking the number of physicians by specialty and county (AmeriGroup);
- Conducting GeoAccess surveys to ensure a certain level of coverage in all specialties (AmeriHealth, Humana PCA);
- Tracking appointment availability (Contra Costa);
- Tracking complaints (Contra Costa); and,
- Tracking the number of members and number/type of providers (Prime Health).

Standard	Reference
State standards regarding travel time and distance. MCO is in compliance with the state's standards regarding the maximum travel and distance times to PCPs and specialists. If no state standards, MCO has method for determining geographic access needs based on distance, travel times, and means of transportation.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISMC 3.1

Nine of the ten MCOs in the sample reported using this standard to assess their networks. Although most of the MCOs used state-established performance measures--usually a 30-minutes-or-30-miles standard--they reported being flexible in its application if circumstances beyond the provider’s control make adherence impractical. Others noted that the unique geographic characteristics of each plan should preclude mandating specific standards. For example, Arizona’s Mercy Care Plan uses precise standards that differ according to whether an area is urban or rural.

Assessment Methods for Geographic Access Standard

Geographic access was the standard most often cited by plans as the easiest to assess. The methods varied from plan to plan, depending on the nature of the standard, but geographic access generally is determined by plotting the location of providers’ offices to ascertain sufficient coverage of a specific geographic area. The method used by the

overwhelming majority of plans was GeoAccess mapping software. Plans not using GeoAccess conduct some other form of geographic mapping.

Standard	Reference
MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services, and urgent care services.	Proposed BBA Rules, Sec. 438.306 (d)(5) & (6); QISMC 3.1.3 & 3.1.4

All of the MCOs reported using this standard to assess their provider networks. All indicated that they thought this a useful and practical standard. One MCO however, reported that it thought requiring the availability of 24-hour, seven-day-a-week routine care would be impractical.

Assessment Methods for 24 Hours/7 Days a Week Access Standard

Plans identified two primary assessment methods to measure performance in relation to this standard: complaint monitoring and phone audits. All of the plans that use complaint monitoring also use phone audits. Phone audits generally involve calling provider offices after hours to determine whether their after-hours systems are set up correctly.

Standard	Reference
MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	Proposed BBA Rules, Sec. 438.306 (d)(6); QISMC 3.1.4

Three of the ten MCOs in the sample reported using this standard to assess their provider networks. Most MCOs indicated that, although they thought providers might want to do this to give themselves a competitive advantage, requiring such a standard would be inappropriate and impractical. They thought the standard impractical for a number of reasons, including the fact that some believed the cost of adding extra hours would make it unpopular with providers. Others thought it unnecessary given that a large proportion of Medicaid recipients is not employed and should therefore be able to access care during regular business hours. Still others reported considering the standard unnecessary because a 24-hour advice line with an accompanying triage service that directs members to after-hours care if necessary accomplishes the same purpose. Finally, some believed it would be difficult to get providers in high crime areas to accept the standard due to potential safety issues.

Assessment Methods for Ensuring Evening and Weekend Hours Standard

Several plans in the survey indicated that, while they do not require their providers to have evening or weekend office hours, it is something that they track as a means to offer complete provider information to their members or to assist with urgent care situations. The information is obtained by site visit surveys, which are most often conducted during the initial contracting process. The information is subsequently updated through the

credentialing site visit process and tracked through member complaints and telephone audits.

Standard	Reference
State standards regarding appointment waiting times. MCO is in compliance with the state's standards regarding appointment waiting times. If no state standards, MCO has method for determining and tracking appointment waiting times.	Proposed BBA Rules, Sec. 438.306 (e)(1)(I); QISMC 3.1.7.1; HEDIS 3.0/1998

All of the MCOs in the sample reported using this standard and meeting the related state standard. Although, as with states, there was a wide variation in the specifics of the standards.

Almost all of the MCOs had differing interpretations of the standard. Some interpreted it as referring to in-office waiting times (e.g., 30-45 minutes), while others interpreted it as referring to the maximum time a member had to wait for an appointment for care (e.g., 21 days for PCP access, 24-48 hours for urgent care access, etc.).

Assessment Methods for Appointment Waiting Times Standard

Three plans (Xantus, Mercy Care Plan, and CalOPTIMA) noted that tracking appointment availability and waiting times is one of the most difficult standards to assess overall. Plans and states alike report that it is difficult to measure these access criteria because it requires soliciting information from PCP staff, for whom there is a disincentive to provide accurate information. Some of the assessment methods employed include:

- Phone surveys of physicians, in which the state or plan official self-identifies (AmeriHealth, Humana PCA, Prime Health); and,
- Phone surveys of physicians, in which the state or plan official does not self-identify (Humana PCA).

Some of the reported problems associated with these methods include:

- Inaccurate information reported by PCP staff;
- Questioning PCP staff without self-identifying engenders distrust and anger from PCPs and their staff; and,
- On-site reviews are sporadic and often announced, which may affect their accuracy.

Given these problems with these assessment methods, member surveys and member feedback were identified as the most effective ways to identify providers or MCOs that are in violation of an appointment timeliness or waiting time standard.

Standard	Reference
MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	Proposed BBA Rules, Sec. 438.306 (e)(1); QISMC 3.1.7.1

All of the MCOs in the sample reported having such a process in place. All the MCOs reported that this standard was among the easiest to understand and implement. Some noted that the standard’s purpose was clear, its objective practical, and its implementation neither difficult nor costly. Nevertheless, three MCOs reported not monitoring providers’ implementation of the timeliness standards.

Assessment Methods for Communicating Timeliness Standard

The processes used by MCOs to meet this standard include:

- Including the timeliness standards in the provider manual (AmeriGroup, Prime Health);
- Explaining the timeliness standards at provider orientations (Prime Health);
- Using mystery shoppers to determine whether providers are meeting the standards (Humana PCA, Mercy Care Plan);
- Conducting member satisfaction surveys to uncover problems with maintaining the standards (Humana PCA); and,
- Tracking member complaints to uncover problems (Humana PCA).

Standard	Reference
The percentage of enrollees aged 20-44, 45-64, and 65 who had an ambulatory or preventive care encounter during the reporting year. Inpatient procedures, hospitalization, emergency room visits, mental health and chemical dependency are excluded.	HEDIS 3.0/1998

Five of the MCOs in the sample that reported using this standard mentioned its connection to the HEDIS standards, and indicated that they consider it a quality standard. The MCOs that reported not using the standard nevertheless indicated that they were required by the states in which they operated to make efforts, and in some cases ensure, that new members visit their PCP within a certain time after enrolling.

Those that do not use the standard indicated they did not do so for a variety of reasons. One indicated that the difficulties associated with the reliability of the information used to contact the Medicaid population in their state made this standard impractical. Another mentioned the difficulties in tracking performance for the standard in a capitated environment because the performance data would have to be collected from encounter data, which was not required of providers in their state.

Assessment Methods for Ambulatory and Preventive Care Encounters Standard

The plans that track performance in relation to this standard do so through the use of:

- Encounter data (AmeriGroup, CalOPTIMA); and,
- Claims reviews (Prime Health).

Standard	Reference
MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventive services.	Proposed BBA Rules, Sec. 438.306 (d)(2); QISMC 3.1.1.2

All of the MCOs in the sample reported that they understood the importance of allowing women to have easy access to women's health specialists, and eight reported that they use this standard in evaluating the adequacy of their networks and also are complying with the standard.

The two MCOs that reported not using the standard indicated nonetheless that they allow women direct access to women's specialists under certain circumstances. Mercy Care Plan, for example, allows women to choose a women's health specialist as a PCP. Humana PCA, meanwhile, indicated that it allows women members direct access to women's health specialists without referral for routine and preventive care.

Assessment Methods for Direct Access Standard

The assessment methods that plans use for this standard include:

- Tracking member grievances (CalOPTIMA, Xantus);
- Reviewing claims to determine if service or payment was denied (Contra Costa); and,
- Reviewing performance to ensure compliance with state criteria (Xantus).

Standard	Reference
The MCO identifies providers whose facilities are accessible to people with disabilities.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISMC 3.5.1.1

Nine of the MCOs in the sample reported using this standard in analyzing the effectiveness of their networks and all considered it useful. However, the performance measures used by each differed, depending in large part on state standards. For example, all MCOs reported applying this standard to hospitals and other institutional providers. Some reported also applying it to physicians, but only to PCPs and OB/GYNs. Others reported applying the standard to all providers.

The MCO that reported not using this standard indicated it did not because the issue was covered under federal and state law.

Assessment Methods for Accessible Facilities Standards

All of the plans that provided assessment methods for this standard indicated that they do so through site visits to provider offices, most often as part of the contracting or credentialing/ recredentialing process.

Standard	Reference
The number of Perinatal Care Level II and Level III facilities in the provider network. The MCO has procedures in place to direct providers to the facilities.	HEDIS 3.0/1998

Only three of the MCOs in the sample reported using this standard to assess the adequacy of their networks. However, although not all indicated they had adopted the standard, all did note their awareness of the EPSDT requirement that they make necessary services available. Moreover, some of those that adopted the standard did not think it particularly useful given that they considered the number of perinatal facilities in a network to be an issue of availability rather than an issue of their willingness to enroll the facilities in the network.

Assessment Methods for Perinatal Care Level II and Level III Facilities Standard

There were no concrete assessment methods reported for this standard. AmeriHealth indicated that it was informally assessed and AmeriGroup indicated that the contracted facilities are identified in the provider directory.

Standard	Reference
Availability of translators in American Sign Language (ASL). MCO is in compliance with the state's standards regarding availability of translators in ASL. If no state standards, MCO has method for ensuring the availability of ASL translators.	STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53

Although only half of the MCOs in the sample reported that they had adopted such a standard for assessing the adequacy of their provider networks, most indicated that they made translators available to members upon request. Those that had not adopted the standard indicated that they had not done so because they believed that existing federal and state laws adequately address the issue.

Assessment Methods for ASL Translator Standard

Tracking member grievances is one of two assessment methods used by MCOs for this standard. The other is to track requests for services and match them against the availability of contractors.

Standard	Reference
Availability of TDD services. MCO is in compliance with the state's standards regarding TDD services. If no state standards, MCO has method for ensuring the availability of TDD services.	STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53

Seven of the ten plans in the sample indicated that they used this standard in assessing the adequacy of their provider network. Eight of the ten responded that they made TDD services available to members. The two MCOs that responded that they did not make TDD services available, indicated they did not do so because the service was offered by the state.

Assessment Methods for TDD Services Standard

Only two plans reported assessment methods for this standard. One plan (CalOPTIMA) indicated tracking it through audits and member grievances. The other indicated that maintaining a TDD line was sufficient for meeting the standard.

Standard	Reference
State has process for ensuring the MCOs have relationships with public health, education, and social services agencies.	HEDIS 3.0/1998

Eight of the ten MCOs in the sample reported using this standard to assess the adequacy of their networks and reported having such a requirement. The two MCOs that reported not having adopted the standard also reported that it was encouraged but not required by the states in which they operated.

The plans that reported using this standard have varying degrees of relationships with the public organizations in their networks. These relationships range from an as-needed basis or as directed by the state, to comprehensive memoranda of understanding with public health, education and social service agencies.

The two MCOs that reported not having adopted the standard nevertheless acknowledged the importance of including these providers in their networks. One reported that it made special efforts to contract with public health clinics and other public organizations. The other stated that it attempts to contract with these providers and agencies as well as maintaining an “open network” for those with which it does not contract.

Assessment Methods for Ensuring Relationships Standard

The assessment method most reported for this standard was the review of written documentation of the relationships, including contracts, memorandums of understanding, and other types of agreements.

One MCO (AmeriHealth) reported tracking the percentage and types of agencies with which they have contracts, memoranda of understanding, or other relationships.

II. Network Quality

Standard	Reference
State evaluates MCOs credentialing and recredentialing process for all providers, including institutional providers.	HEDIS 3.0/1998; QISMC 3.1.2

Eight of the ten MCOs in the sample reported using this standard, and reported having it imposed on them by the state. Nevertheless, all the respondents acknowledged the standard's importance. The MCOs that reported not having adopted the standard indicated that they maintained such a credentialing process for their network.

Assessment Methods for Credentialing /Recredentialing Standard

This standard is assessed through the following methods:

- Audits of health networks (CalOPTIMA);
- Reviews of provider credentials (Contra Costa);
- State audits and self-audits (Mercy Care Plan); and
- A computer software program (Prime Health).

Standard	Reference
Percentage of providers who receive initial orientation to the plan and on-going training from the plan.	New Jersey Care 2000 HMO RFI Released for Public Comment, Volume I, NJ Dept. of Human Services, DMAHS, March 1998, page VI-3

Six of the ten MCOs in the sample reported using this standard to assess the adequacy of their networks and all reported seeing the value of such a standard. Nevertheless, none wanted to see the standard include a specific percentage of providers. Some considered it was unnecessary and others infeasible.

The MCOs that have adopted this standard reported setting a goal of 100% for orienting new PCPs and varying goal levels for specialists and other provider types.

All of the plans that reported not having adopted such a standard nevertheless indicated that they did offer an orientation for new PCPs and other providers. They also indicated that they offered on-going training. MCOs operating in more mature markets indicated less of a need for the orientation because of the relatively small numbers of new providers coming into their networks.

Assessment Methods for Orientation and Training Standard

In order to track orientation and on-going provider training, MCOs reported using the following methods:

- Review of data self-reported by providers (CalOPTIMA);
- Review of attendance logs for orientations (Prime Health); and,
- Visits to providers by provider relations representatives (Xantus).

Standard	Reference
MCO has procedures in place to timely identify and furnish care to pregnant women.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.2

Seven of the MCOs reported using this standard to assess the adequacy of their managed care networks. However, all MCOs acknowledged understanding the importance of early identification of, and early prenatal care for pregnant women. The two MCOs that reported not having adopted the standard indicated that although they had no stated standard they still attempted to identify pregnant women in a timely fashion and provide them prenatal care early in their pregnancy. For example, Managed Health Services, one of the MCOs that reported not having adopted the standard, reported it had not done so because the lack of appropriate data makes it difficult to implement. Nevertheless, they are working with claims data and local health departments to develop a suitable means for identify pregnant women timely.

Assessment Methods for the Timely Identification and Provision of Care to Pregnant Women Standard

A great amount of resources is expended on ensuring that pregnant women receive appropriate prenatal care. Many plans reported special prenatal care programs that assist them in encouraging women to seek care and in tracking pregnant women. To determine whether women are receiving appropriate care, plans rely on activities such as chart reviews, HEDIS audits, and provider reports.

The challenge in assessing compliance with this standard has less to do with identifying appropriate care than with the timely identification of pregnant women. Several plans indicated that they have struggled with innovative ways to ensure that women who are pregnant or suspect that may be get in touch with their provider or with the plan early on. These include providing information in member handbooks and conducting other forms of member outreach. Quite a few participants identified this as a problem area. One plan indicated that it receives a pregnancy indicator on the enrollment files for the state. This information enables them to identify pregnant women but is only useful when a woman is a new member.

Standard	Reference
MCO has procedures in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.3

Six of the MCOs in the sample reported using this standard in assessing the adequacy of their networks. The MCOs that indicated they had not adopted this standard indicated they had not done so for a variety of reasons. For example, one MCO noted that it thought it would be a useful standard but was difficult to implement unless the state provided identifying information and treatment histories. Other MCOs indicated that they had not adopted such a standard but did have procedures in place to identify members with serious and complex medical conditions, as well as members who were at-risk for such conditions. They also had processes in place to assess their needs and provide appropriate treatment, but saw no need for a standard.

Assessment Methods for the Timely Identification and Provision of Care to Individuals with Complex and Serious Medical Conditions Standard

The assessment methods used to identify and furnish care to people with chronic and complex conditions included the following:

- Tracking referrals to disease/care management through chart reviews and other mechanisms (AmeriGroup, Prime Health, Humana PCA, CalOPTIMA);
- Informal review of utilization and case management data (AmeriHealth);
- Tracking member grievances (CalOPTIMA);
- Concurrent review (Humana PCA); and,
- Claims reviews (Humana PCA, Prime Health).

As is the case with tracking pregnant women, these methods focus more on whether members are receiving appropriate care than on their initial identification in a timely manner.

Standard	Reference
MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	QISMC 3.1.1.1 & 3.1.1.2

Five of the MCOs reported using this standard to assess the adequacy of their network. Those that reported not having adopted the standard acknowledged the importance of having such a process and indicated that they do provide care management services to members who did need them. However, they indicated they did not have such a standard because they did not believe that all individuals with complex and serious medical conditions require care management services.

Assessment Methods for Care Manager Standard

The following mechanisms are used to ensure that members who are identified with complex and serious medical conditions are assigned to care managers:

- Chart reviews (AmeriGroup);
- Encounter reports (AmeriGroup);
- Informal review of utilization and case management data (AmeriHealth);
- Audits of case management files (CalOPTIMA); and,
- Tracking member grievances (CalOPTIMA).

III. Cultural Competence

Standard	Reference
MCO has process for identifying significant sub-populations within the enrolled population that may experience special barriers in accessing health services, such as the homeless or certain ethnic groups.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5

Four of the ten MCOs in the sample reported using this standard to assess the adequacy of their networks. The plans that have adopted such a standard indicated that it is difficult to implement and were not certain that it was cost effective.

Most of the MCOs that reported not having adopted such a standard indicated that they had not done so because of the difficulty associated with obtaining the information required to implement it.

Assessment Methods for Sub-populations Standard

Although four MCOs indicated that they are using this standard, only one provided assessment methods. This MCO (CalOPTIMA) indicated that it tracks member grievances as a way to determine whether it is succeeding in reaching out to sub-populations. It also depends on feedback from a committee of community advocates to help gauge its success in this area.

Standard	Reference
Ratio of providers who speak a language other than English to the number of Medicaid recipients (total recipients , not just MCO members) who speak the same language.	QISMC 3.1.5

One of the MCOs in the sample reported using this standard to assess the adequacy of its network. All respondents reported recognizing the importance of including providers in the network who were fluent in the language(s) spoken by members, but those that had not adopted the standard indicated they did not believe such a standard would be practical or effective. Nevertheless most of the MCOs that had not adopted it reported that they

made serious efforts to recruit providers who were fluent in languages spoken by a significant number of their members.

Assessment Methods for Bilingual Providers Standard

None of the MCOs surveyed used a ratio to ensure the availability of a sufficient number of providers who speak languages other than English. However, quite a few MCOs indicated that they track providers who speak languages other than English and make this information available to members. One plan (Mercy Care Plan) reports information to the state on a quarterly basis regarding Spanish-speaking providers.

Another MCO indicated that it keeps track of members who speak languages other than English through the eligibility data provided by the state, and uses this information to help determine whether its bilingual capacity is adequate.

Standard	Reference
MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and arrangements for interpreter services.	Medicaid HEDIS 2.0/2.5

Five of the MCOs in the sample reported using this standard and having such a process in place. Three of the MCOs that reported not having such a standard or process indicated nevertheless that they did attempt to hire and retain bilingual staff. The remaining plans that reported not having adopted the standard indicated that the population they serve includes only a small number of members who do not speak English, and they are served through the AT&T Language Line.

Assessment Methods for Bilingual Capacity Standard

The methods used by MCOs to ensure sufficient bilingual capacity among staff and to provide arrangements for interpreter services differed quite a bit from plan to plan. The one thing that most plans had in common was their use of the AT&T Language Line for translation services. However, only one respondent indicated using a staffing ratio to ensure that there was an adequate number of member-interface staff who spoke particular languages. Another MCO cited an overall commitment to recruiting and employing Spanish-speaking staff as the method that they use to meet this standard. A third MCO used the tracking of member grievances as its primary assessment method.

Standard	Reference
MCO offers cultural competency training that educates providers about the medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5

Four of the MCOs in the sample reported using this standard to assess the adequacy of their networks. They all operate in states that have significant minority populations and have developed sophisticated cultural competency education programs. One of the MCOs regarded this training as a means to give itself a competitive advantage with potential members.

Three of the MCOs that reported not having adopted the standard indicated nonetheless that they considered it potentially useful. One of the three indicated that its network was built around traditional providers who were assumed to be culturally competent, and it therefore saw little need to provide additional training.

In general, most MCOs thought that the goal behind the standard was important, but doubted the wisdom of, or need for a government-mandated standard.

Assessment Methods for Cultural Competency Training Standard

Two of the four MCOs that offer cultural competency training provided assessment methods for this standard. One indicated that it reviews provider survey responses to determine whether its training is successful in meeting provider needs. The other indicated that it reviews attendance records to identify which providers are attending training sessions.

FINDINGS: INTERVENTIONS

Instituting a process to improve performance is critical in ensuring provider network adequacy. This section includes information about the interventions used by the states interviewed to address problem areas with plans, outlines some of the materials employed by states and plans to assist them in this process, and highlights some of the network success stories reported to the project team by states and plans.

States are engaged in an on-going struggle between the demands of their dual role as regulator and purchaser of health care services. In general, the interventions used by a state are determined by the way it approaches this role and defines its relationship with the MCOs. As regulator, states may favor interventions that are proscriptive, developing interventions that are highly structured and that incorporate performance measures that include little or no flexibility. However, as purchasers who rely on a dynamic market, states may favor interventions that utilize performance measures that are more flexible in order to account for the changing conditions in the market.

The relationship between the states and the MCOs can also be affected by factors such as the size of the state, the structure and maturity of the Medicaid managed care program, and the structure and number of the plans participating in the program. The smaller states in the survey, including Rhode Island and Delaware, reported very close working relationships with the MCOs in their states. These relationships are partly due to the relatively small number of staff on both sides.

More mature Medicaid managed care programs have policies and procedures that have been refined and improved over time. As a result, they may have relationships with MCOs that are well-defined and run more smoothly than those in states with less mature programs.

Processes

States use varying degrees of formality when they are interacting with MCOs concerning problem areas.

Interventions are often implemented in accordance with a process laid out in the contract. However, plans and states alike report that the process can be formal or informal, depending on the nature and severity of the problem.

The basic intervention process, as reported by most respondents, generally involves three steps.

- Step one: The state identifies a problem area, either through the submission of a routine report by the MCO, through member feedback, or through some form of audit or review;
- Step two: The state notifies the MCO of the problem, either in writing or via phone. The state communicates to the MCO the time frame it has to correct the problem. It may also require that the MCO submit a corrective action plan or document and submit a proposed solution to the problem; and,

- Step three: Once the allotted time has expired, the state will revisit the issue, review all documentation, and contact the MCO again. If the problem has not been corrected or resolved, the state may extend the time allotted for corrective action or take punitive action against the plan.

Punitive actions vary according to the nature and severity of the problem and the state's contract provisions, and may entail monetary fines, withheld premiums, or suspended member enrollment.

Two respondents (Florida and CalOPTIMA) reported using an additional process to resolve problems with plans. They provide MCOs with a forum to discuss program or statewide problems as a group. This process is not used in lieu of the punitive action but is seen as a complementary process. Meeting times for these forums vary from monthly, to bimonthly, to quarterly. They are attended by MCO representatives and state administrators and provide opportunities for both to discuss new developments, changes, and problem areas.

Assessment Materials

States and MCOs use a variety of materials, such as surveys and policies and procedures, for assessing or assuring Medicaid managed care provider network adequacy. The following section discusses several examples which are included in Appendix C. The samples tools discussed are:

- Readiness assessment tool;
- Health network performance review guide;
- Provider office site visit tool and medical record audit tool;
- Member complaint annual summary;
- Provider satisfaction survey; and,
- Cultural competence and related policies and procedures.

Readiness Assessment Tool

The readiness assessment tool, a sample of which is included on the following page as Exhibit 1 and excerpts of which appear in Appendix C-1, was selected from the "STAR/STAR+PLUS Readiness Assessment Tool, September 1997" provided by the Texas Department of Health. It is similar to tools used by other states to determine whether a plan is in compliance with its contract provisions. This particular tool is used to review an MCO's readiness to begin accepting Medicaid members and is first used prior to the initial enrollment period. It identifies both problem areas and areas of strength.

EXHIBIT 1: READINESS ASSESSMENT TOOL

HMO: _____
 Reviewer(s): _____

Category: _____
 Date: _____

**REVIEWER'S GUIDE
 STAR/STAR+PLUS READINESS ASSESSMENT TOOL**

Element #	Contract	Phase	Desk /Site	Critical Review Element ¹	Validation Method	(If not met) Corrective Action/Deadline
11. Provider Network						
11A	7.9.2 7.10.1	I	D/S	HMO has an adequate network of PCPs and specialty providers.	Desk: <ul style="list-style-type: none"> Review maps created on geo-mapping software showing locations of contracted providers specified below (one map per provider type listed.). Each map should contain Service Area and county boundaries, county seats and major towns, and distance scale. Provide a map for each of the following provider types: <ul style="list-style-type: none"> PCPs OB/GYNs Pediatric subspecialties (e.g. pediatric cardiologists Vision providers THSteps providers Hospitals FQHCs Rural Health Clinics Psychiatrists Other behavioral health providers Site: <ul style="list-style-type: none"> On-site review of materials/documentation showing HMO has an adequate network of all provider types, including specialists. Discuss provider network adequacy with staff. 	Network must be in place before implementation of program.

¹= Critical review elements are applicable to both STAR and STAR+PLUS unless designated with a [*], which designates STAR+PLUS only.
 *= STAR+PLUS Contract
 [*]= Critical review element for health plans which will be operating in STAR+PLUS program.

As illustrated in the sample there are several critical pieces of information included in the tool. They are:

- Element number and contract section: This references the contract provisions that are being reviewed;
- Phase: This references the time period of the review (i.e., between the signing of the contract and the implementation of the program);
- Desk/Site: This indicates whether the review is conducted on-site at the MCO administrative offices or through a desk review at TDH;
- Critical Review Element: This is the particular contract provision that is being reviewed;
- Validation Method: These are the methods used to determine whether the MCO's performance meets the objectives of the contract provision; and,

- **Corrective Action/Deadline:** This provides the action that should be taken and the time frame that MCOs should be given to improve performance in relation to the critical review element.

The above sample highlights a critical review element requiring that the HMO have an adequate network of PCPs and specialty providers. There are both desk review and site review validation methods for this standard.

Network Performance Review Guide

The review tool excerpts that are included in Exhibit 2 and Appendix C-2 were selected from the “Health Network Performance Review Guide, January 1998” provided by CalOPTIMA. The document serves as an integrated tool for CalOPTIMA’s regulatory oversight of contracted health networks. The Review Guide addresses the health network’s structure and process in areas of operational, financial, and clinical performance. The guide makes up one part of an on-going review process that includes focused reviews on a quarterly or as-needed basis.

As indicated in the CalOPTIMA document, each review area has several individual performance standards.

EXHIBIT 2: NETWORK PERFORMANCE REVIEW GUIDE												
Health Network Performance Review Guide Provider Management												
PM.1 The health network has availability and accessibility of all required health care services							Weighted Score Rec'd	0.00	#DIV/0!			
							Weighted score possible	0.00				
Reference: Contract for Health Care Provider Services, Article II, Section C							0	1	2	3	4	N/A
A	The health network provides appropriate services with provisions including but not limited to: 1. PCP assignment ratio of no more than 1 PCP per 2000 members 2. One (1) Specialist per 1200 members 3. One (1) Mid-level per 1000 members 4. Emergency services 5. PCP coverage 24 hours a day, 7 days a week						Recommendations:					
							0	0.00	0.00			

Under each performance standard there are provisions. Each provision is weighted on a 10-point scale, based on its importance relative to the performance standard. The standard is then scored and the MCO is rated, in the following categories, based on its score:

- Substantial compliance-- consistently meets all components of the standard;
- Significant compliance-- meets most components of the standard;
- Partial compliance-- meets some components of the standard;
- Minimal compliance-- meets few components of the standard;
- Non-compliance-- insignificant components of the standard are met; and,
- Not applicable-- standard does not apply to the structure of the organization.

Recommendations regarding each standard are made based on the plan's performance in each of the provisional areas, rated independently and as a whole.

Site Visit Tool and Medical Record Audit Tool

Appendix C-3 includes a copy of the "Practitioner Office Site Evaluation, August 1998" and Appendix C-4 includes a copy of the "Practitioner Clinical Medical Record Audit, August 1998," provided by AmeriGroup. Both of these forms are used by AmeriGroup in conducting provider site visits as part of the credentialing and recredentialing process.

The site evaluation is divided into several categories, each representing a different area of review. They include:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical records;
- Appointment availability;
- Documentation evaluation; and,
- Office evaluation.

Each of these categories is assigned a point value, based on a total scale of one hundred points. Each question within a category is assigned a point value as well. Action is taken by the plan depending on the score of the physician.

The medical record audit consists of twenty-seven questions, each assigned a relative point value based on a total of one-hundred points. As with the site visit, action is taken depending on the score of the physician.

Member Complaint Annual Summary

Appendix C-5 includes a copy of the "Member Complaint Annual Summary, Plan Year XV, October 1996 to September 1997" provided by Mercy Care Plan in Arizona. This annual summary provides a detailed analysis of the types of complaints received, broken out by:

- Those related to service;
- Those related to clinical care;
- Provider category;
- Individual provider; and,
- Those related to county and program.

The summary also includes a sample complaint form that illustrates the coding process for each category of complaint falling under the headings of service issues and quality issues. The service issues include:

- Accessibility and availability issues;
- Communication/relationship issues;
- Administration;
- Billing issues; and,
- Transportation issues.

The quality issues include:

- Treatment issues;
- Office environment;
- Medication issues; and,
- Inappropriate provider behavior.

This summary is used by Mercy Care Plan to track the nature and volume of complaints made to the plan over time. While most complaints are addressed immediately as part of the member complaint process, categorizing them in this way enables the plan to identify problem areas from a plan-wide perspective.

Provider Satisfaction Survey

Appendix C-6 includes a copy of the “Texas Medicaid Managed Care (STAR and STAR+PLUS) Provider Satisfaction Survey” provided by the Texas Department of Health. The survey consists of thirty-five questions and is organized into three categories:

- Clinical care;
- Administration and organization; and,
- Overall feeling about Medicaid managed care and basic demographics.

The intent of the survey is to solicit information from providers about Medicaid managed care in general, about specific experiences they have had in dealing with the Medicaid managed care program, about particular plans, and about their experience and their practice in particular.

Cultural Competence and Related Policies and Procedures

Appendices C-7 through C-10 contains four policy letters provided by the State of California Health and Human Services Agency, Department of Health Services. Each of the policy letters addresses cultural competence or a related issue.

The first, “MMCD Policy Letter 99-01 regarding Community Advisory Committees,” provides clarification concerning the responsibilities of Medi-Cal managed care plans in implementing and maintaining community linkages through the formation of a Community Advisory Committee.

The second, “MMCD Policy Letter 99-03 regarding Linguistic Services,” clarifies Medi-Cal managed care plans’ contract requirements concerning the provision of cultural and linguistic services.

The third, “MMCD Policy Letter 99-04 regarding Translation of Written Informing Materials,” provides clarification concerning Medi-Cal managed care plans’ contract responsibilities in providing quality translation of written informing materials to members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards.

The fourth, “MMCD All Plan Letter 99005 regarding Cultural Competency in Health Care - - Meeting the Needs of a Culturally and Linguistically Diverse Population,” provides a definition of cultural competency in health care and guidelines for plan administrative implementation and training and education. It also provides guidance on the relationship between cultural competency and quality improvement efforts.

The intent of each of these policy letters is to help clarify or provide guidance to plans regarding some important operational issues.

Success Stories

Part III of the interview protocol asked both states and MCOs to identify any success stories they had in identifying and remedying a problem related to network adequacy. Almost all of the success stories centered on increasing access to providers and included the following:

- Increasing access to dental services;
- Increasing the number of physicians participating in the Medicaid program;
- Utilizing physician extenders to increase access;
- Increasing access for the disabled; and,
- Improving access to pediatric specialists.

Increasing Access to Dental Services

Two states and one plan reported success in increasing access to dentists. Plans in Minnesota are required to provide dental care within a certain geographic area. If they fail to contract with dental providers within the required distance, they may be responsible for transporting members to dentists outside the area. Many dentists have been resistant to contracting, so plans have instituted innovations such as developing an externship program with the local dental school. Through this program, MCOs sponsor dental students at sites in the community, external to the school. They are able to make arrangements for services for their members through the program. Another initiative consists of using a mobile dental services unit to meet members’ needs.

Both the state of Tennessee and the plan that was interviewed in Tennessee (Xantus) reported success in dental care coverage. From the state perspective, the success is due to

its aggressive requirements for ensuring that the MCOs are in compliance with contractual provisions regarding dental services: access and availability. The state noted that, during one reporting period, all nine MCOs reported deficiencies. Within thirty days four of the MCO's had corrected the problem, and within sixty days seven of the nine had done so. In Tennessee, violations of this kind result in withheld premiums, so the plans are under pressure to correct the problems. On the plan side, the dental services problem was viewed as a result of several things: low reimbursement rates, the dentists' lack of need for additional patients, and their discomfort with the Medicaid program and benefit structure. In order to increase access to dentists, the MCO concentrated its efforts on recruiting dentists by entering into special negotiations to pay higher rates and contracting with some out-of-state providers.

Increasing Number of Physicians Participating in Medicaid

Two states reported success in increasing the number of physicians willing to participate in the Medicaid program.

Rhode Island reported a greater than 200% increase in participating physicians in their RItE Care program during their first year of operation. There had been a shortage of PCPs in poor, under-served areas. RItE Care administrators called a meeting with the CEOs of the MCOs to discuss the problem and come up with a plan. Through a collaborative effort they were able to recruit additional physicians and increase PCP capacity in those areas.

In Florida, the Agency for Health Care Administration (AHCA) reported that the MCOs have been successful in recruiting providers for Medicaid managed care that the state was unable to recruit for Medicaid fee-for service. This is due, in part, to the ability of the MCOs to use commercial contracts with the providers as leverage.

Utilizing Physician Extenders to Increase Access

Two states (Texas and Arizona) reported success in using physician extenders to increase access to services. Arizona employs nurse practitioners to reach a very remote rural population. Texas is currently exploring the option of employing visiting nurses to reach members in outlying areas where the numbers of primary care providers is inadequate.

Increasing Access for the Disabled

CalOPTIMA reported success in increasing access for the disabled by developing the Disability Community Liaison Program (DCLP) which has dedicated liaisons that help disabled members meet their care needs. One of the programmatic improvements resulting from the DCLP is a Seating Clinic that assists members in obtaining wheelchairs. The program also allows some medical supplies to be ordered twelve months at a time without prescription renewals.

Improving Access to Pediatric Specialists

Prime Health, an MCO in Alabama, which was having problems in the areas of pediatric urology and neurology, reported some success in improving access to pediatric specialists. Prime Health communicated directly with specialists in the area, as well as with the State, about the need to improve access for its members. In one instance, it had one-on-one informal discussions with a particular pediatric neurologist who agreed to expand his member load and increase his referral acceptance.

CONSIDERATIONS

As new developments in provider network adequacy come to light through federal legislation, HCFA initiatives, or state-sponsored activities, state administrators are faced with the challenge of incorporating these changes into the operation of their Medicaid managed care programs. In order to assist administrators in this process, this section will:

- Summarize some important questions to consider when faced with new developments in provider network adequacy;
- Provide a framework for incorporating new standards and assessment methods; and,
- Provide a helpful tool for working through the steps in the framework.

Important Questions

There are several things that should be considered by Medicaid managed care administrators regarding new developments in the area of provider network adequacy. Whether the new developments are required as a result of legislation, or self-initiated, the following questions should be addressed:

- How does this standard improve access to, or the quality of care provided to Medicaid recipients?
- How does this standard fit the objectives of our Medicaid managed care program? How does it relate to our existing standards?
- What are the strengths and weaknesses of the existing provider networks in our state, and how will this standard affect them?
- Is the standard realistic? Is it feasible to collect and evaluate the information needed to assess performance?
- What are the administrative, financial, and other resource cost implications of adopting this standard for the state and for the MCOs? Are the potential benefits worth the potential cost?
- What is our current relationship with the MCOs in the state and how will they react to this standard?

These questions enable administrators to begin to sort through some of the issues associated with incorporating new standards. The answers help administrators determine whether they should act on a proposed standard, if it is optional, and to develop a plan of action, if the standard is mandatory.

Framework

Once a decision is made about acting on a new standard, the administrator should begin a process of incorporating it into the program. An eight-step suggested framework for doing so follows. The steps are listed sequentially. However, in some cases it may be appropriate to address them in a different order.

Step 1: Identify new standards

Review regulations and other documentation to identify new standards. When it is a new regulation and therefore required, identify and clarify each requirement. When it is a suggested change or new development, extract the items that are of greatest interest and relevance to the program. In very precise language, detail the standard and its source.

Step 2: Compare to existing standards

Once the new standards are identified, review existing standards to determine whether there are any that are currently in use that are identical or similar to the new standard. Succinctly summarize the existing standards that fall into this category and cite their source. Also, take some time to identify performance measures, performance levels, assessment methods, and interventions currently used with that standard. Compare and contrast the new with the existing standards to determine whether current ones meet the objective or focus of the new ones. If the new standards are due to a regulation, determine whether the existing standard meets the regulatory requirements. If there are significant differences, determine what changes have to be made to refocus the current standard.

Step 3: Refine definition of standard

Once the difference, if any, between the new and existing standards is clear, refine the language of the new ones to meet the objectives of the particular Medicaid managed care program. In the case of a regulatory requirement, this must be done within the bounds of the regulation. It may involve adding language that strengthens the standard or makes it more specific. Conversely, it may involve loosening the requirements imposed by the standard.

Step 4: Define performance measure

Once the standard language is clarified and refined, quantifiable performance measures should be identified where appropriate. This process, which began with the initial questions regarding the feasibility of collecting the necessary information, should focus on defining specific, measurable data points that serve as an accurate reflection of performance for the particular standard.

Step 5: Define performance levels

To the extent possible, or necessary, levels of performance that define network adequacy should be attached to the performance measures. The performance levels should reflect a range, with unacceptable performance at one end and extraordinary performance at the other. The range will make it possible to evaluate the performance of an MCO in relation to a standard. The structure and specificity of the performance levels will depend on the nature of the standards (i.e., whether they are quantitative or qualitative, whether there can be different levels of performance, etc.). Performance levels for existing similar standards should be taken into consideration and consistency should be maintained.

Although having and using quantifiable performance measures, is critical, it is equally critical to be flexible in applying them.

EXHIBIT 3: Example, Network Adequacy Worksheet*

<p>Determine based on the nature of the new standard and established measures for existing standards</p>	<p>New Standard</p> <p>MCO has a process in place for determining the capacity of PCPs to serve Medicaid members. This capacity determination considers the volume of services being furnished to patient's other than the MCO's enrollees.</p> <p>Source: BBA Proposed Regulations, Sec. 438.306 (d)(1)(iii)</p>	<p>List regulation, other language and source</p>
	<p>Current, Similar Standard(s)</p> <p>Contractor agrees to assign no more than 1,250 Medicaid members to any single PCP in its network. For PCP teams and PCP sites, Contractor agrees to assign no more than 1,100 Medicaid members per single primary care provider within the team or site.</p> <p>Source: Any State Medicaid Managed Care Contract</p>	<p>List any similar existing standards, and their sources, to compare and contrast with new one</p>
<p>Develop based on the nature of the performance measures and existing assessment methods</p>	<p>Possible Performance Measures</p> <ul style="list-style-type: none"> • Effective process for determining the number of the provider's active Medicaid and non-Medicaid members (i.e., through a provider survey) • Effective process for determining whether the provider's panel is open or closed • Effective process for determining the capacity of the provider to see Medicaid members based on the total number of active patients and the provider's ability to meet access and availability standards (i.e., through a patient upper-limit, through a provider survey, through telephone audits or on-site reviews) 	<p>Develop based on the nature of the standard and performance levels for existing standard</p>
	<p>Possible Performance Levels</p> <p>Exceeds Expectations: MCO has effective process for determining capacity of providers that considers the volume of services provided to both Medicaid and non-Medicaid members. The process determines whether the provider's panel is open or closed. This capacity determination includes an evaluation of the provider's ability to meet access and availability standards.</p> <p>Meets Expectations: MCO has effective process for determining capacity of providers that considers the volume of services provided to both Medicaid and non-Medicaid members.</p> <p>Non-Compliance: MCO has process for determining capacity of providers that only considers the volume of services provided to Medicaid members.</p>	
	<p>Possible Assessment Methods</p> <ul style="list-style-type: none"> • Desk audit of MCO policies and procedures and documented processes • Periodic MCO reports regarding provider active patient load, both Medicaid and non-Medicaid • Tracking of member complaints • Periodic MCO reports regarding provider compliance with appointment availability and timeliness standards 	
	<p>Interventions</p> <ul style="list-style-type: none"> • Issue written warning to MCO with required time frame for corrective action • Provide suggestions to MCO regarding effective processes for meeting the standard 	

* A blank copy of this tool is included in Appendix D

Step 6: Define assessment methods

Determining how the performance measure data will be collected and evaluated is a critical step in adopting a new standard. As with Step 4, the assessment methods for a particular standard should be considered early in the process. A standard can be a great idea in theory, but if it is infeasible or cost prohibitive to collect the necessary data, then instituting it should be questioned. To minimize the use of additional resources and

maintain consistency, assessment methods for new standards should be incorporated into existing processes to the extent possible. For example, adapting a current report to include an additional data field may be preferable to creating a separate report and reporting process. When establishing the assessment method, it is also important to establish the periodicity of data collection and evaluation.

It is also important that the assessment method that is adopted include a feedback mechanism. MCOs expect to have their performance measured and want to hear about performance that might not be up to standard before it becomes an issue.

Step 7: Identify interventions

Interventions that can be used to improve performance when needed must be identified. These interventions may derive from an existing contractual compliance process or, depending on the nature of the standard, they may be specially derived in response to one of its features. This step is important because it answers the critical question of how to handle a plan that is not performing in an acceptable manner.

Step 8: Begin formal adoption process

Once the decision is made to incorporate a particular standard, the formal adoption process must begin. This process may involve legislation at the state level, MCO contract revisions or addenda, or policy statements issued by the appropriate administrator. It is to the state's advantage to communicate with the MCOs about proposed additions or changes in standards, performance measures, performance levels, assessment methods, and interventions.

Framework Tool

Exhibit 3, on page 78 is a tool developed to assist administrators in working through the steps outlined in the framework. The table was completed using a sample standard to demonstrate the type of issue that may be considered. A full-sized blank copy of the worksheet is included in Appendix D.

APPENDICES

Appendix A	Methodology
Appendix B	Performance Standards Summary
Appendix C	Sample Assessment Tools and Other Materials
Appendix D	Network Adequacy Worksheet
Appendix E	Summary of Key BBA Proposed Regulations, Sec. 438.306
Appendix F	QISMC Domain 3: Health Services Management
Appendix G	Bibliography

Appendix A: Methodology

The intent of this project was to develop a useful tool that administrators of state Medicaid programs could use in assessing Medicaid managed care provider network adequacy. Because Medicaid managed care programs are complex and differ from state-to-state, one of the most effective ways to provide state administrators with guidance is providing concrete examples of what different states are doing to address similar issues.

Building on this idea and working in conjunction with HCFA, PwC designed a six-step process to provide maximum value to administrators. This process consisted of the following steps:

- Step 1: Developing a list of standards;
- Step 2: Selecting states and plans for participation in the interview and survey process;
- Step 3: Conducting the interviews and surveys of states and plans;
- Step 4: Reviewing RFPs and contracts;
- Step 5: Reviewing assessment tools; and,
- Step 6: Developing the final report.

Each of these steps is described in further detail in the following section.

Step 1: Development of List of Standards

The project team, consisting of PwC and HCFA staff, developed an initial, comprehensive list of provider network adequacy standards based on a review of existing and proposed regulations, state contracts, quality improvement programs, and other materials. In developing this list, the team considered the relevance each had to current regulations, their relationship with commonly acceptable standards, and the usefulness and feasibility of collecting the information. From the initial list, which contained more than fifty standards, the team selected twenty five standards which addressed any or all of the following network adequacy objectives: (a) access to or availability of care; (b) network quality; and (c) cultural competence.

These three network adequacy objectives were chosen as they are requisite characteristics of Medicaid managed care network adequacy. Access to or availability of care, network quality, and cultural competence are all part of a well rounded approach to achieving network quality. Each objective in and of itself reflects core elements of a quality Medicaid managed care network. See Appendix B for a list of the performance standards.

Step 2: Selection of States & MCOs

In designing the data collection process, the project team decided to select a small sample of states and MCOs that would provide a wide array of information regarding provider

network adequacy. The state and plan selection process combined both quantitative and qualitative elements. The states and MCOs selected to participate were not intended to be a statistically representative sample. Rather, the states and MCOs were selected for their diversity in some areas and their similarities in others. Specifically, criteria for states included:

- A minimum of three states had to have Medicaid managed care programs in operation for at least 5 years;
- All states had to have 10% or more of Medicaid population enrolled in managed care;
- Three states had to have 50% or more of Medicaid population enrolled in managed care;
- A minimum of two states had to have overall managed care penetration of greater than 25%;
- All states had to have a mandatory Medicaid managed care program;
- In a minimum of four states, the ethnic and racial minorities had to constitute at least 10% and 20% of the Medicaid population respectively; and,
- At least two states had to have a total Medicaid population less than 200,000.

Criteria for the plans included:

- A minimum of five plans had to have a minimum enrollment of 20,000;
- A minimum of seven plans had to have Medicaid enrollment that equaled a minimum of 50% of plan's total enrollment; and,
- A minimum of two plans had to operate plans in more than one state.

The team selected ten states and ten managed care organizations. Once they were approved by HCFA, HCFA contacted the state and MCO administrators to invite them to participate in the project. The characteristics of the states and the MCOs interviewed and their locations are summarized in Tables 1 through 4.

The MCOs selected included a wide variety of for profits and not-for-profits; single and multi-state plans; and large and small plans. Two of the MCOs, Contra Costa and CalOPTIMA are health insuring organizations (HIOs). They, like most states, function as both regulators and purchasers of health care, however, they do so for a limited geographical area. Because they are responsible for maintaining network adequacy standards imposed by the state, this report includes them in the MCO category.

Step 3: Conducting the Interviews

Once the standards were agreed upon and approved by HCFA, the team developed an interview protocol for use in conducting two, one and one half-hour telephone

interviews with each state and MCO. Similar protocols were prepared for the states and the MCOs and consisted of a three page questionnaire about network adequacy in general (see Table 5) and included a survey (see Table 6) addressing the specific standards. The protocol was sent to the interview participants in advance of the scheduled interview date to allow them time to prepare their responses and gather relevant information. The interviewees consistently invited experienced staff members from within their organization or agency to participate in the interviews. In general, participants were eager to participate in the project and were candid in their responses.

The interview protocol was divided into three parts:

- Part I focused on the processes used by states and MCOs to assess network adequacy;
- Part II, which referenced the survey, solicited specific information about their utilization of the standards, performance levels, assessment methods, feasibility, and sources of the standards; and,
- Part III focused on identifying best practices and interventions to improve performance.

The interviews were conducted by two-person teams, a lead person conducting the interview and a second person probing for additional information and taking notes. The team conducted an initial interview, focusing on the processes states and MCOs use to assess network adequacy and identification of interventions to improve performance. The team then conducted a follow-up interview, focusing on specific information about state and MCO utilization of the standards, performance levels, assessment methods, and sources of the standards. The two-interview process allowed the respondents time to complete the detailed survey, and provided the team the opportunity to both focus the discussion and clarify any issues from the first interview.

Step 4: Review of Contracts and RFPs

In addition to the information collected verbally through the interviews, the project team reviewed the most recent Medicaid managed care contracts and/or requests for proposals (RFPs) for Medicaid managed care for the state and MCO participants, when available. In most cases, these were obtained by the HCFA project officer through the HCFA regional offices. The team utilized a grid to identify any relevant references in these documents to the list of standards. These references were summarized in a matrix format that matched the project standard to the RFP and/or contract citation and the participant's survey response.

The intent of this process was to uncover any information that may not have been addressed in the interview, to compare the RFPs and/or contracts to the verbal

responses, and to provide further insight about the inclusion of certain provider network adequacy standards in current programs. See Table 7 for a list of the reviewed RFPs and contracts.

Step 5: Review of Assessment Tools

As part of the interview process, the project team requested that participants provide copies of any non-proprietary materials that they utilize in their assessment or assurance of Medicaid managed care provider network adequacy, such as surveys, checklists, policies and procedures, and other tools. The intent was to select comprehensive and/or innovative samples and include them as part of the report to provide administrators with concrete examples that they could adapt for their purposes.

Step 6: Developing the Report

The processes outlined above led to a wealth of information regarding Medicaid managed care provider network adequacy from both the state and the MCO perspective. The method utilized by the project team to systematically analyze and summarize the information included tallying the responses to the interview questions and worksheets, analyzing the contracts and RFPs, and summarizing the information provided regarding the utilization of each of the standards, the assessment methods employed, and the interventions used to improve performance.

The project team organized the findings into two sections: Performance Standards and Interventions. The Performance Standards section includes a discussion of the standards, the contract and RFP language, and the assessment methods. The Interventions section includes a discussion of the interventions used by states to assist plans in improving performance and highlights sample assessment tools.

The Considerations section of the report provides a framework for incorporating new standards into the network assessment process and guidance on utilizing this report.

Table 1: States Interviewed

Arizona, California, Connecticut, Delaware, Florida, Iowa, Minnesota, Rhode Island, Tennessee, Texas

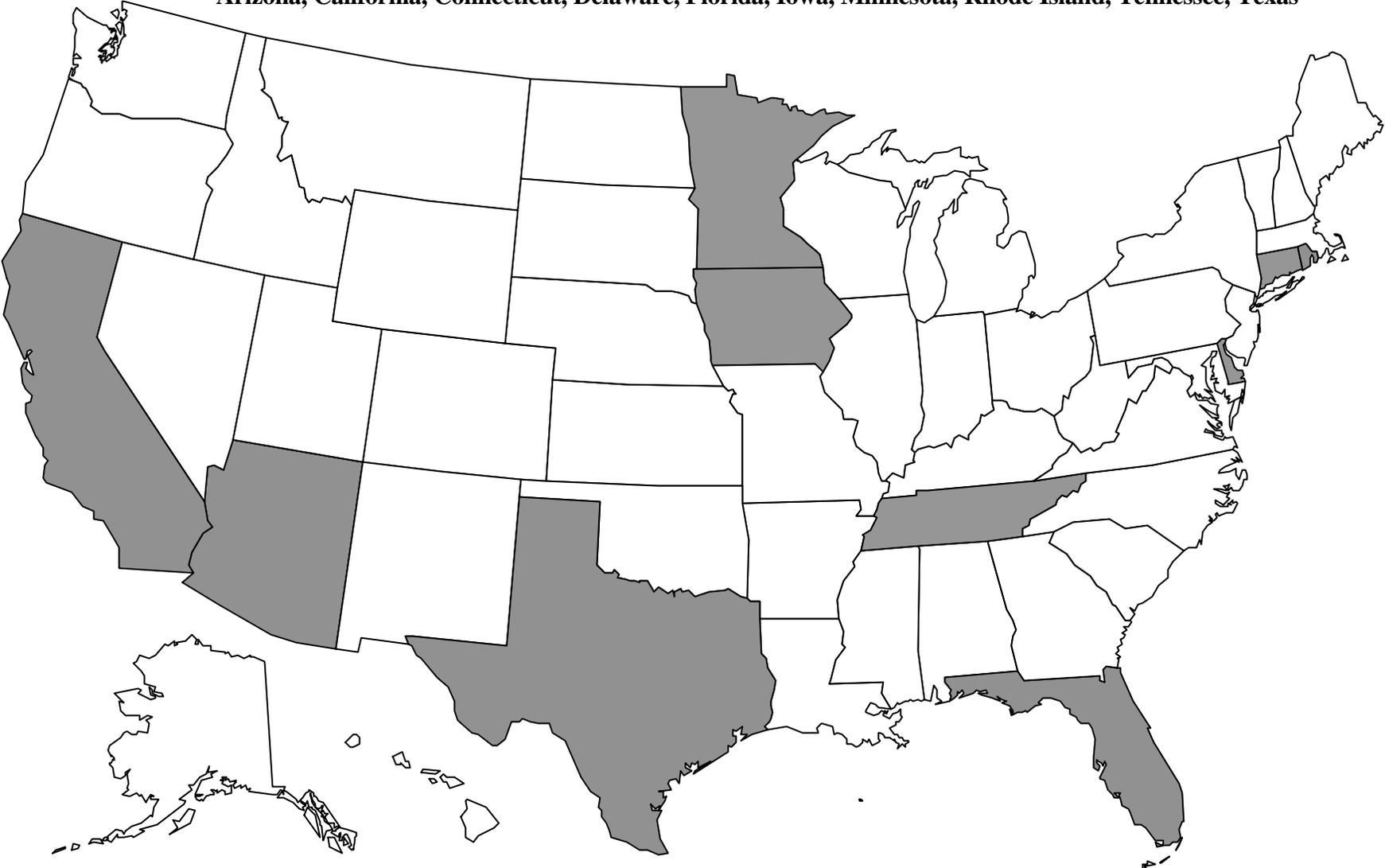


Table 2: State Interviewee Characteristics

State	Size of Medicaid Population	Percent of Medicaid Population Comprised of Ethnic and/or Racial Minorities	Percent of Medicaid Population Enrolled in Managed Care	Years of Operation for Medicaid Managed Care Program in the State	Number of MCOs Participating in Medicaid Managed Care Plans
Arizona	432,809	N/A	85.11%	15	33
California	4,901,159	55.07%	45.83%	12	49
Connecticut	307,243	40.71%	71.87%	3	5
Delaware	80,794	53.74%	76.75%	3	3
Florida	1,417,854	48.00%	64.57%	7	17
Iowa	206,981	12.45%	92.13%	8	7
Minnesota	428,842	25.02%	52.58%	13	8
Rhode Island	117,800	27.93%	63.20%	5.5	4
Tennessee	1,268,769	30.49%	100.00%	5	9
Texas	1,719,249	68.33%	25.47%	5	12

Explanation of Column Headings and Data Sources

Size of Medicaid Population:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration.

Percent of Medicaid Population Comprised of Ethnic and/or Racial Minorities:

The ethnic and/or racial minorities included in this count are Black Not Hispanic, Native Americans, Asian or Pacific Islanders and/or Hispanic

Source: On-line, Medicaid Recipients of Medical Care by Race/Ethnicity and By State: Fiscal Year 1997. <http://www.hcfa.gov/medicaid/MCD97T24.htm>

Percent of Medicaid Population Enrolled in Managed Care:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration.

Years of Operation for Medicaid Managed Care Program in the State:

Source: Online: APWA, National Association of State Medicaid Directors Active 1915(b) Waivers. <http://medicaid.aphsa.org/1915bactive.HTM>; Verified through direct contact with states.

Number of MCOs Participating in Medicaid Managed Care Plans:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration; Verified through direct contact with states.

Table 3: MCOs Interviewed and the States They Do Business in

AmeriChoice (AC), AmeriGroup (AG), AmeriHealth (AH), Buyer's Health Plan (BH), CalOPTIMA (CO), Humana PCA (HP), Contra Costa (CC), Centene (CC), Mercy Care Plan (MC), Prime Health (PH), Xantus (XT)

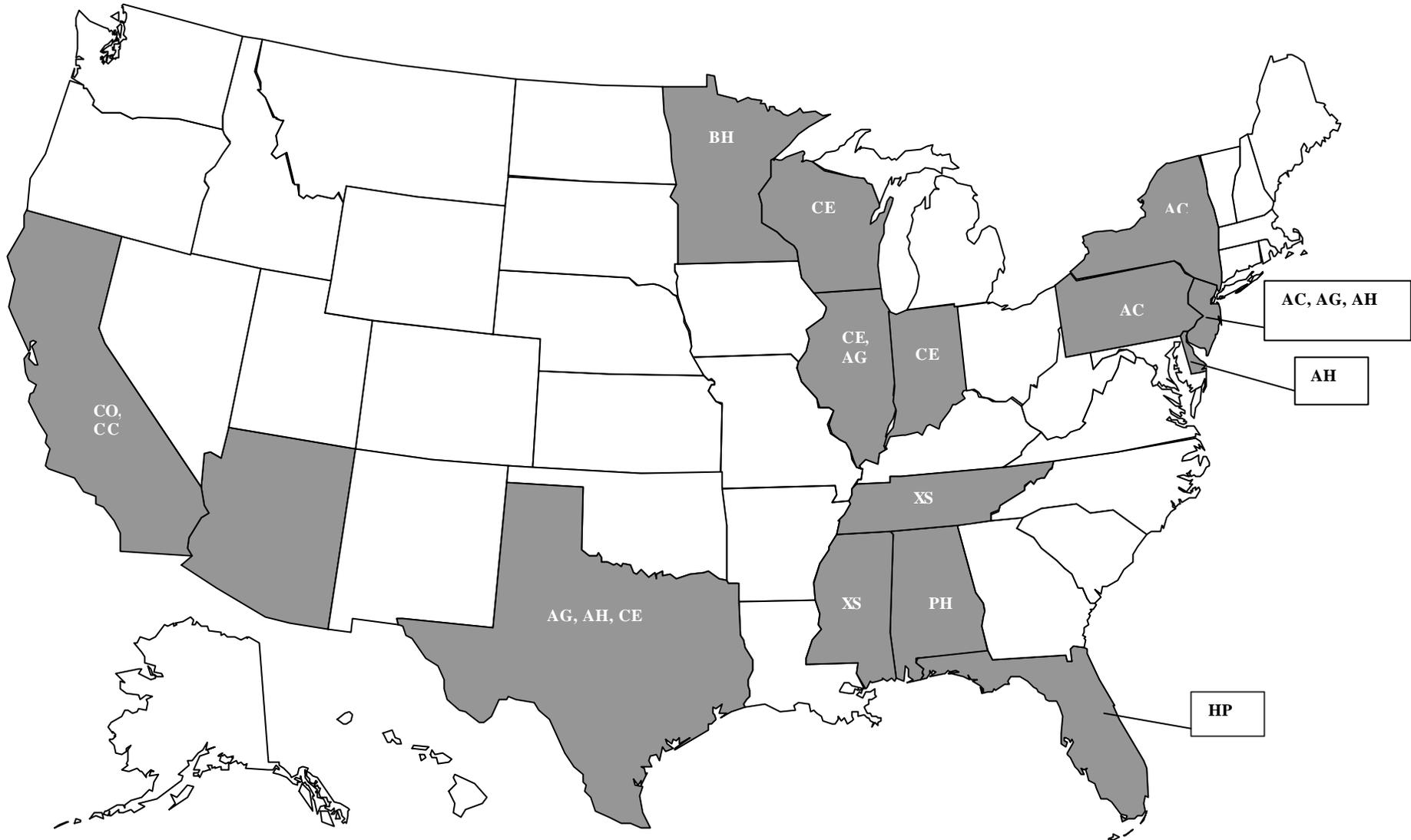


Table 4: MCO Interviewee Characteristics

Plan	States in Which They Operate Medicaid MCOs	Total Number of Medicaid Lives	Medicaid Only MCO	For Profit/ Not-for-Profit	Structure
AmeriChoice	NJ, NY, PA	134,994	Yes	For Profit	MCO
AmeriGroup (Americaid)	IL, NJ, TX	110,540	Yes	For Profit	MCO
AmeriHealth	NJ, DE, TX	54,303	Yes	For Profit	MCO
Buyer's Health Plan Action Group	MN	N/A	N/A	N/A	Group Purchasing Organization
CalOPTIMA	CA	205,604	N/A	Not-for-Profit	HIO
Contra Costa	CA	40,363	Yes	Not-for-Profit	HIO
Centene (Managed Health Services)	IL, IN, TX, WI	48,037	Yes	For Profit	MCO
Mercy Care	AZ	71,447	Yes	Not-for-Profit	MCO
Humana PCA	FL	123,061	No	For Profit	MCO
Prime Health	AL	37,841	Yes	Not-for-Profit	MCO
Xantus (formerly Phoenix Health Care)	TN, MS	181,031	Yes	For Profit	MCO

Explanation of Column Headings and Data Sources

States in Which They Operate Medicaid MCOs:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration; Verified through direct contact with MCOs.

Total Number of Medicaid Lives:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration.

Medicaid Only MCO:

Source: Medicaid Managed Care Enrollment Report, June 30, 1998, Health Care Financing Administration.

For Profit/ Not-for-Profit:

Source: The Interstudy Competitive Edge 8.2, Part I: HMO Directory, September 1998; Verified through direct contact with MCOs.

Structure:

Source: The Interstudy Competitive Edge 8.2, Part I: HMO Directory, September 1998; Verified through direct contact with MCOs.

Table 5: State Interview Protocol

Medicaid Managed Care Provider Network Adequacy State Medicaid Agency Interview Protocol

Introduction

The purpose of this interview is to elicit information in the following areas:

- Measures of adequacy that states consider when they are developing the requirements for a Medicaid managed care network;
- The most effective methods states use to assess network adequacy; and,
- The most effective methods that States have noted MCOs use in improving performance in the selected areas.

These standards may be reflected in federal or state regulations, the RFP issued by the state, the contract between the state and the MCOs, or other similar requirement/commitment documents. The focus of these questions is the general Medicaid population.

Interview Questions

Part I: Process for Assessing Medicaid Managed Care Provider Network Adequacy

1. Please describe the process your State has in place to assess the adequacy of Medicaid managed care networks in your State.
 - Do you work with other entities or outside contractors to conduct the assessments?
 - How frequent are the assessments? Are there some things you look at more frequently than others? Why?
 - What are the major areas of focus?
 - Do you conduct site visits?
 - Does your assessment process differ for new plans versus mature plans?
 - Please describe any instruments utilized to conduct the assessments.
 - Can you provide us with a copy of the instrument(s) for our records?

2. How do your standards or processes compare to the HMO licensing requirements in your State?
 - Do you share information or collaborate with the HMO licensing agency in your State about the network assessment process or outcomes?
 - Can you describe their network assessment process for us?
 - Can you provide us with a contact person?

Part II - Measures of Network Adequacy and Performance Levels

3. Please refer to the Performance Standards Worksheet that you completed and faxed to us. The table lists the standards along the left side of the table and 9 questions regarding each across the top of the page.
 - What is your general reaction to each of the standards?
 - Do you think they would be useful to you in measuring network adequacy?
 - Do you think it would be feasible to collect this information? Why or why not?
 - Should they be more or less specific?
 - Do you use any standards to measure provider network adequacy that are not reflected in the list included in the table? Please describe.

Part III - Monitoring Network Adequacy, Identifying Best Practices and Identifying Interventions to Improve Performance

4. In assessing the adequacy of MCO networks, what areas do you find easiest to assess and evaluate? What areas do you find particularly challenging?
 - How do you determine whether a network is adequate or acceptable?
 - How do you use the information you collect as an integrated set to make decisions?
 - How do you integrate the information into your decision-making processes?
5. How did you set your standards of acceptability?
 - Federal requirements
 - State requirements
 - Practice standards
 - Historical practices
 - Other sources
6. If there is an area in need of improvement, how do you work with the MCOs to address it? How is it addressed by the MCOs? Can you site any success stories or examples of improvement?
7. Does your State have any plans to change the way in which it assesses the adequacy of Medicaid managed care networks? If so, what are they?

Table 6: State Performance Standard Survey Questions

The following questions were asked of each state for each standard listed in Appendix B. A similar set of questions were asked of each MCO.

1. Do you utilize this standard?
2. Do you require a certain level of performance? If so, what is it?
3. What is the range or approximate level of performance or situation that you see in the networks in your state?
4. If you do not use the standard listed, please list any related ones that you do use.
5. Is this standard based on federal/state regulations or other sources?
6. How do you assess this standard?
7. What information do you use to assess it?
8. Is performance monitored by the State, the MCO, or both?

Table 7: List of Reviewed Contracts and RFPs

STATE	REVIEWED CONTRACTS AND RFPs
Arizona	Arizona Health Care Cost Containment System Acute Care RFP (October 1998)
California	Contract with Contra Costa Health Plan (no date); CalOPTIMA Contract for Health Care Services (no date)
Connecticut	Purchase of Service Contract Between the CT Department of Social Services and MCO (As of January 19, 1999)
Delaware	Department for Health and Social Services, Request for Proposals for MCOs (1999)
Florida	Medicaid Health Maintenance Organization Contract (1998-2000)
Indiana	Managed Health Services Contract, January 1997; State of IN RFP F1-9-643 (1998)
Iowa	Contract for Services SFY 1999; Iowa Administrative Code 441-Ch.88; Managed Health Care Providers Request for consideration (August 9, 1993)
Minnesota	Model Contract for Prepaid Medical Assistance Program Services, Prepaid General Assistance medical Care Program Services and Managed Care Program Services (no date)
Rhode Island	Harvard Pilgrim Health Care of New England RIte Care Contract (July 1998)
Tennessee	A Contractor Risk Agreement Between The State of Tennessee, d.b.a. TennCare and (Name of Contractor) (September 11, 1995)
Texas	Request for Application, Medicaid Managed Care, Texas Department of Health (June 17, 1998)

Appendix B: Performance Standards Summary

Appendix B- Standards Summary

STANDARD	REFERENCE	UTILIZATION BY STATES * (out of a total of 10)	UTILIZATION BY MCOs (out of a total of 9)
Access to or Availability of Care			
PCP to Member ratio	Proposed BBA Rules, Sec. 438.306 (d)(1); QISM 3.1.1.1	9	9
For each provider type, including primary care providers, determine the following: the number and percentage that serve Medicaid patients; and the number and percentage that accept new Medicaid patients.	HEDIS 3.0/1998	5	6
Provider turnover by provider type (including primary care providers)	HEDIS 3.0/1998	2	4
MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands.	Proposed BBA Rules, Sec. 438.306 (d)(1); QISM 3.1.6	5	6
State standards regarding travel time and distance. MCO is in compliance with the state's standards regarding the maximum travel and distance times to PCPs and specialists. If no state standards, MCO has method for determining geographic access needs based on distance, travel times, and means of transportation.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISM 3.1	10	8
MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services, and urgent care services.	Proposed BBA Rules, Sec. 438.306 (d)(5) & (6); QISM 3.1.3 & 3.1.4	9	9
MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	Proposed BBA Rules, Sec. 438.306 (d)(6); QISM 3.1.4	2	3
State standards regarding appointment waiting times. MCO is in compliance with the state's standards regarding appointment waiting times. If no state standards, MCO has method for determining and tracking appointment waiting times.	Proposed BBA Rules, Sec. 438.306 (e)(1)(I); QISM 3.1.7.1; HEDIS 3.0/1998	10	9
MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	Proposed BBA Rules, Sec. 438.306 (e)(1); QISM 3.1.7.1	5	7

* This table summarizes the written survey responses of the states and the MCOs. The numbers do not necessarily reflect actual use of the standards due to some incomplete responses and variations in interpretation.

STANDARD	REFERENCE	UTILIZATION BY STATES* (out of a total of 10)	UTILIZATION BY MCOs (out of a total of 9)
MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventive services.	Proposed BBA Rules, Sec. 438.306 (d)(2); QISMC 3.1.1.2	7	6
The percentage of enrollees aged 20-44, 45-64, and 65 who had an ambulatory or preventive care encounter during the reporting year. Inpatient procedures, hospitalization, emergency room visits, mental health and chemical dependency are excluded.	HEDIS 3.0/1998	4	5
State has process for ensuring the MCOs have relationships with public health, education, and social services agencies.	HEDIS 3.0/1998	9	7
The MCO identifies providers whose facilities are accessible to people with disabilities.	Proposed BBA Rules, Sec. 438.306 (d)(1)(v); QISMC 3.5.1.1	7	8
The number of Perinatal Care Level II and Level III facilities in the provider network. The MCO has procedures in place to direct providers to the facilities.	HEDIS 3.0/1998	5	3
Availability of translators in American Sign Language (ASL). MCO is in compliance with the state's standards regarding availability of translators in ASL. If no state standards, MCO has method for ensuring the availability of ASL translators.	STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53	6	5
Availability of TDD services. MCO is in compliance with the state's standards regarding TDD services. If no state standards, MCO has method for ensuring the availability of TDD services..	STAR Program RFA for Dallas and El Paso, 1998, Texas Department of Health (TDH), page 53	6	7
Network Quality			
State evaluates MCOs credentialing and recredentialing process for all providers, including institutional providers.	HEDIS 3.0/1998; QISMC 3.1.2	9	8
Percentage of providers who receive initial orientation to the plan and on-going training from the plan	New Jersey Care 2000 HMO RFI Released for Public Comment, Volume I, NJ Dept. of Human Services, DMAHS, March 1998, page VI-3	4	5
MCO has procedures in place to timely identify and furnish care to pregnant women.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.2	9	7

Appendix B- Standards Summary

STANDARD	REFERENCE	UTILIZATION BY STATES* (out of a total of 10)	UTILIZATION BY MCOs (out of a total of 9)
MCO has procedures in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	Proposed BBA Rules, Sec. 438.306 (e)(3); QISMC 3.1.1.3	8	6
MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	QISMC 3.1.1.1 & 3.1.1.2	6	5
Cultural Competence			
MCO has process for identifying significant sub-populations within the enrolled population that may experience special barriers in accessing health services, such as the homeless or certain ethnic groups.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5	5	4
Ratio of providers who speak a language other than English to the number of Medicaid recipients (total recipients , not just MCO members) who speak the same language	QISMC 3.1.5	1	0
MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and arrangements for interpreter services.	Medicaid HEDIS 2.0/2.5	8	5
MCO offers cultural competency training that educates providers about the medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served.	Proposed BBA Rules, Sec. 438.306 (e)(4); QISMC 3.1.5	3	4

Appendix C: Sample Assessment Tools*

- C-1: Excerpt from Readiness Review Tool**
- C-2: Excerpt from Network Performance Review Guide**
- C-3: Practitioner Office Site Visit Evaluation**
- C-4: Practitioner Clinical Medical Record Audit**
- C-5: Excerpt from Annual Complaint Summary**
- C-6: Provider Satisfaction Survey**
- C-7: Community Advisory Committee Policy**
- C-8: Linguistic Services Policy**
- C-9: Translation of Written Informing Materials Policy**
- C-10: Cultural Competency Policy Letter**

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

Appendix C-1* :
Excerpt from the “STAR/STAR+PLUS
Readiness Assessment Tool, September 1997,”
Texas Department of Health

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

HMO: _____
 Reviewer(s): _____

Category: _____
 Date: _____

**REVIEWER'S GUIDE
 STAR/STAR+PLUS READINESS ASSESSMENT TOOL**

Element #	Contract	Phase	Desk/ Site	Critical Review Element	Validation Method	(If Not Met) Corrective Action/Deadline
				11. Provider Network		
11A	7.9.2 7.10.1	I	D/S	HMO has an adequate network of PCPs and specialty providers.	Desk: <ul style="list-style-type: none"> • Review maps created on geo-mapping software showing location of contracted providers specified below (one map per provider type list). Each map should contain Service Area and county boundaries, county seats and major towns, and distance scale. Provide a map for each of the following provider types: • PCPs • OB/GYNS • Pediatric subspecialties (e.g. pediatric cardiologists) • Vision providers • THSteps providers • Hospitals • FQHCs • Rural Health Clinics • Psychiatrists • Other behavioral health providers Site: <ul style="list-style-type: none"> • On-site review of materials/documentation showing HMO has adequate network of all provider types, including specialists. Discuss provider network adequacy with staff. 	Network must be in place before implementation of program.

Element #	Contract	Phase	Desk/ Site	Critical Review Element	Validation Method	(If Not Met) Corrective Action/Deadline
11B	7.9.2.3	I	S	HMO has PCP availability throughout the entire service area.	<ul style="list-style-type: none"> • Discuss process for ensuring providers' proximity to public transportation. • Discuss process for ensuring that the PCP network meets the following requirements. <ul style="list-style-type: none"> • The PCP network is sufficient to serve 45% of the mandatory eligible clients in each county • All PCPs have admitting privileges at contracted hospital or be able to refer Members to providers who do • Discuss system to monitor patient load, which can not exceed 1,500 Members for each PCP (unless there are physician extenders, which is used to expand capacity by 750) and 2,500 Members under age 18 for each pediatrician. • Contact sample of providers by phone. 	Network must be in place before implementation of program.
11C	6.13.1	I	S	HMO has a primary care and specialty care provider network for persons with disabilities or chronic or complex conditions.	<ul style="list-style-type: none"> • Discuss how HMO has determined whether provider offices have any access barriers for disabled. 	Network must be in place before implementation of program.
11D	6.13.8 7.11	II	S	HMO includes specialty care hospitals in provider network. HMO ensures that hospitals provide pre-admission planning and discharge planning, ensuring notification by HMO of discharges to Member/family, PCP, and specialty care physicians. Provider network includes transplant, trauma, and hemophilia centers.	<ul style="list-style-type: none"> • Review related documentation and contracts/agreements with hospitals and providers. • Discuss utilization management or case management function with responsibility and procedures for processing inpatient prospective, concurrent and discharge utilization planning • Contact random sample of hospitals 	Network must be in place before implementation of program.

Element #	Contract	Phase	Desk/Site	Critical Review Element	Validation Method	(If Not Met) Corrective Action/Deadline
11E	7.13	I	S	HMO has given Significant Traditional Providers the opportunity to participate in its provider network. STPs in network understand client capacity.	<ul style="list-style-type: none"> Validate HMO contacts with STPs by interviews with HMO staff and on-site documentation review. Review number of STPs identified; number applied; and number contracted with. Discuss HMO's understanding of SB10 and limits on STPs. On-site review of IPA credentialing standards to ensure that they do not place barriers to STP participation Discuss procedures for continued recruitment efforts and participation in HMO committees. 	HMO must show evidence that it has attempted to contract with STPs before Phase II.
11F	7.9.1	II	S	HMO has an adequate monitoring system that evaluates the length of time it takes Members to access care within the network and monitors after-hours availability	<ul style="list-style-type: none"> On -site documentation review and systems demonstration. 	Policies and systems must be in place before implementation of program.
				12. Network Adequacy		
12A	7.9.6	I	S	HMO has a network that meets standards for availability and 24-hour accessibility	<ul style="list-style-type: none"> On-site review of random sample of executed contracts with PCPs, specialists, hospitals, and transportation providers who can provide access for Members with disabilities. 	Network must meet standards before Phase II. If the network is not complete during Phase I, the HMO must present a written plan for contracting the appropriate number and type of providers before the review can proceed.
12B	7.10.1	I	S	HMO has a recruitment plan for adequate number of specialty care providers.	<ul style="list-style-type: none"> Discuss plans related to specialty care providers. 	HMO should have an adequate plan by the end of Phase I, in order to complete contracting by Phase II. The plan should be in place within 7 days of the Phase I visit.

Element #	Contract	Phase	Desk/ Site	Critical Review Element	Validation Method	(If Not Met) Corrective Action/Deadline
13 Provider Services						
13A	7.4.1	II	D/S	Provider Manual must be submitted to TDH/TDHS 30 days prior to implementation. Provider manual must include elements listed in 7.4.1.	Desk: <ul style="list-style-type: none"> Review provider manual for required elements. Cultural competency section should include cultural practices, e.g., coining. Behavioral health section should include all provider requirements related to behavioral health, education, data submission, coordination of care, and detailed listing of services and clinical protocols. Site: <ul style="list-style-type: none"> Discuss HMO's distribution plan of manuals by implementation date. 	HMO must submit provider manual for review no less than 30 days before implementation of program.
13B	7.4.2	II	S	HMO conducts training for providers and their staff. Training includes contract requirements; special needs of STAR/STAR+PLUS Members; and cultural and linguistic competency.	<ul style="list-style-type: none"> Discuss training plans and materials. Training should include: <ul style="list-style-type: none"> cultural practices and information about the AFDC/Medicaid population. behavioral health services as required in 7.4.2.2 (PCPs only) Discuss qualifications of staff conducting training. On-site review of training schedule for accessibility On-site review of attendance rosters and follow-up procedures for absent providers. Discuss training content Contact random sample of providers by phone to discuss their awareness of STAR/STAR+PLUS requirements, policies and procedures. 	HMO must conduct all necessary staff and provider training before implementation of program.

Element #	Contract	Phase	Desk/ Site	Critical Review Element	Validation Method	(If Not Met) Corrective Action/Deadline
13C	7.7.1	II	D/S	HMO has a written provider complaint and appeal procedure for network providers.	Desk: <ul style="list-style-type: none"> Review provider manual (or draft). Site: <ul style="list-style-type: none"> Interview complaint staff. 	Must be in place and HMO staff and contracted providers must be informed of these policies before implementation of program.
				14. Member Services		
14A	8.2.1	II	D	HMO has developed systems to ensure that Members are aware of health plan policies and procedures.	<ul style="list-style-type: none"> Review Member Handbook (or draft). 	Must be in place and HMO staff, contracted providers and Members must be informed of these policies before implementation of program.
14B	8.2	II	D/S	Member Handbook includes information contained in section 8.2 of contract.	Desk: <ul style="list-style-type: none"> Review Member Handbook (or draft) to ensure that it contains all required information. Site: <ul style="list-style-type: none"> On-site demonstration of software used for readability. Review level of specificity of information Discuss whether Member Handbook has been reviewed by focus groups consisting of clients and client advocates. Discuss Member Handbook distribution plan. 	HMO must submit Member handbook for review no less than 30 days before implementation of program.
14C	8.7	I	S	Member Appeals and Fair Hearings plan includes information contained in section 8.7 of the contract. HMO has policy on informing Members regarding adverse action to deny, delay, reduce or terminate services.	<ul style="list-style-type: none"> Discuss Member Appeals and Fair Hearings. Review sample of Member notice for level of specificity and readability. 	Must be in place and HMO staff, contracted providers and Members must be informed of these policies before implementation of program.

Appendix C-2* :
Excerpt from “Health Network Performance
Review Guide, January 1998,” CalOPTIMA

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

							Weighted Score Rec'd	0.00	#DIV/0!					
							Weighted Score possible	0.00						
MS. 1 The Member Services Department shall have a comprehensive management plan, structural program description, or a Member Services Manual Reference: Contract for Health Care Provider Services, Amendment 1, Article III; RFP Section 5.01							0	1	2	3	4	n/a		
A.	Member Services Management plan or Manual shall, at a minimum, have the following provisions:					(5 points)	Recommendations:							
	1	Goals and objectives												
	2	Comprehensive departmental Policies and Procedures												
						0	0	0	0	0		0	0.00	0.00
B.	Provisions for staffing include:					(5points)	Recommendations:							
	1	Job Descriptions												
	2	Sufficient personnel (full and part-time) to carry out the program's activities												
	3	Confidentiality statements signed by all staff												
						0	0	0	0	0		0	0.00	0.00
C.	There is a provision for the Disability Liaison Program (DCLP) to increase access to health care services for members with disabilities					(10points)	Recommendations:							
	1	The health network notifies members with disabilities of DCLP availability												
	2	There is a designated health network staff member to work directly with CalOPTIMA and the DCLP												
	3	The health network has a documented process for communication within the health network's medical affairs and member services department and the DCLP liaison.												
						0	0	0	0	0		0	0.00	0.00

MS. 3	The health network has appropriate mechanisms to provide for communication with members and internal staff							Weighted Score Rec'd	0.00	#DIV/0!
								Weighted Score possible	0.00	
Reference: Contract for Health Care Provider Services, Article II Sections F,V,W,X, HH; RFP Section 5.01		0	1	2	3	4	n/a			
A.	Documentation is available that substantiates CalOPTIMA approval of all written communication that is sent to members (10 points)							Recommendations:		
		0	0	0	0	0		0	0.00	0.00
B.	Materials provided to members are linguistically correct (10 points)							Recommendations:		
1	Materials are written at required 4th - 5th grade level requirement (SMOG or Flesch-Kincaid grade level test)									
2	Materials are available in the primary threshold languages that comprise at least 5% of the health networks' membership									
		0	0	0	0	0		0	0.00	0.00
C.	The health network has an effective telephone system for answering and responding to member phone calls (10 points)							Recommendations:		
1	Telephone lines are adequate for the health network's line of business (low wait times, abandonment rates)									
2	Management reports are generated and analyzed to evaluate efficacy of phone system (usage, abandonment rates, call waiting times, volumes)									
3	An after-hours call system is in place that provides for 24-hour member availability (See 24-hour access study)									
		0	0	0	0	0		0	0.00	0.00
D.	The health network offers translation services to members including: (10 points)							Recommendations:		
1	Telephone and in-person translation services									
2	Translation services for sight and hearing impaired									
		0	0	0	0	0		0	0.00	0.00

							Weighted Score Rec'd	0.00	#DIV/01						
							Weighted Score possible	0.00							
							0	1	2	3	4	n/a			
CM. 1	The health plan has a written Case Management plan														
	Reference: Contract for Health Care Provider Services Amendment I, Article III														
	A.	The written plan has provisions for annual review and revision (5 points)								Recommendations:					
	1	Review has taken place within the last year													
	2	Appropriate signatures are present													
3	Review approval is reflected in the appropriate meeting minutes														
						0	0	0	0	0			0	0.00	0.00
B.	The plan includes the following program elements: (10 points)								Recommendations:						
1	Criteria for admission into Case Management Services														
2	Provisions for Special Needs population														
3	Case finding (I.e.: transplants, multiple trauma, prematurity)														
4	Number of active cases equals benchmark of 1% of CalOPTIMA membership														
						0	0	0	0	0			0	0.00	0.00
C.	Staffing elements include: (10points)								Recommendations:						
1	Case managers are licensed RNs or professionally prepared individuals with equivalent clinical or health care experience														
2	The staffing ratio is 1 FTE to no more than 60 open cases														
						0	0	0	0	0			0	0.00	0.00

Appendix C-3* :
“Practitioner Office Site Evaluation,
August 1998,” AmeriGroup

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

PRACTITIONER OFFICE SITE EVALUATION

Initial Credentialing

Recredentialing

Physician Name(s):

Office Manager:

Last First

Last First

Office Address:

Physician Specialty:

Date:

Reviewer Name:

	Point Value	Last First			Point Score
		Y	N	N/A	
A. Physical Accessibility:	12				
Is there handicapped accessibility? (First floor access ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office?)	3				
Is handicapped parking clearly marked? (Sign or painted symbol on pavement?)	3				
Are exits clearly marked?	3				
Are building and office suites clearly identifiable (clearly marked office signs)?	3				
B. Physical Appearance:	12				
Is the office clean and well kept? (Neat appearance, no trash on floor, furniture in good repair, no significant spills on floors/furnishings?)	3				
Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor?)	3				
Easy access to a clean, supplied bathroom? (Soap, toilet paper, hand towels and hand washing instructions?)	3				
Fire extinguishers clearly present and fully charged, or a sprinkler system?	3				
C. Adequacy of Waiting and Examining Room space:	14				
Is there adequate seating in the waiting area (based on number of physicians)?*	2				
Does the staff provide extra seating when the waiting room is full?	2				
Is there a minimum of 2 exam rooms per scheduled provider?	2				
Is there privacy of exam room? (Doors or curtain closures, exam rooms cannot be visualized from waiting room)	2				
Are exam rooms reasonably sound proof? (Conversation cannot be heard from waiting room or other exam rooms)	2				
An otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible? OR For OB/GYNs only or any physician providing OB Care: Does the office have the following readily accessible: (If not OB/GYN, check N/A) - A fetalscope (DeLee and /or Dopler) and a measuring tape for fundal height measurement? - Supplies for dipstick urine analysis (glucose, protein)?	2				
D. Adequacy of Medical Records:	22				
Are there individual patient records?	3				
Are records stored in a manner which ensures confidentiality? (Is there a written confidentiality policy and can staff verbalize the process for release of medical records?)	3				
Are all items secured in the chart?	2				
Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	2				
Medical Recordkeeping practices:					
Is there a place to document allergies?	2				
Is there a place to document current medication list?	2				
Is there a place to document current chronic problems list?	2				
Is there an immunization record on pediatric charts?	2				
Is there a growth chart on pediatric charts?	2				
Is there a place to document presence/absence and discussion of patient self-determination/advance directive? (If not appropriate, check N/A)	2				

* 1 Provider = 6 seats, 2 Providers = 8 seats, 3 Providers = 11 seats, 4 Providers = 14 seats, and 5 Providers = 17 seats

	Point Value	Y	N	N/A	Point Score
E. Appointment Availability: Is the physician available:	20				
1 Routinely within a wait time of 45 minutes or less? (Ask office manager)	2				
2 At least 4 days or 20 hours per week?	2				
3 For 24 hour call coverage for emergencies? (By themselves or by a covering provider?)	3				
4 For urgent care within 12 hours?	3				
5 For routine primary (non-chronic) care within 72 hours?	2				
6 For routine care within 4 weeks?	2				
7 OB/GYNS only : For a first visit after pregnancy determination (excludes home pregnancy test) within 14 days?	2				
8 Specialists only : For referrals from PCPs for urgent care within 3 days? (For PCPs, check N/A)	2				
9 Specialists only: For referrals from PCPs for non-urgent care within 4 weeks? (For PCPs, check N/S)	2				
F. Documentation Evaluation: Does the office have the following:	8				
1 No-show follow-up procedures/policy?	3				
2 A chaperon policy?	3				
3 A written policy for handwashing, gloved procedures, and disposal of sharps?	2				
G Office Evaluation:	12				
1 Is there an approved process for biohazardous disposal?	2				
2 Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	3				
3 Are vaccines and other biologicals refrigerated, as appropriate?	2				
4 Observe 2-3 office staff interactions: Are they professional and helpful?	3				
5 Is emergency equipment available (an oral airway and ambu bag)?	2				

To complete the form, answer every question, then total the number of points and record here.

TOTAL

Miscellaneous Items:

Does the office have the AMERICAID Provider Manual? Check N/A, if pre-operational.

Are you receiving the AMERICAID newsletter? Check N/A, if pre-operational.

A copy of this complete profile was received by:

Office Manager/Physician (please circle one)

Appendix C-4* :
“Practitioner Clinical Medical
Record Audit, August 1998,” AmeriGroup

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

PRACTITIONER CLINICAL MEDICAL RECORD AUDIT

Physician Name: _____
Last First

Office Address: _____

Physician Specialty: _____ Date _____ Reviewer: _____
Last First

Patient Name: _____ Chart/Member # _____

	Point Value	Y	N	N/A	Point Score
1 Is chart accessible?	4				
2 Do all pages contain patient ID (name/ID#)?	4				
3 Are there personal /biographical data?	3				
4 Is the provider identified on each entry?	4				
5 Are all entries dated?	4				
6 Is the record legible?	4				
7 Is there a completed problem list?	4				
8 Are allergies and adverse reactions to medications prominently displayed?	4				
9 Is there an appropriate past medical history in the record?	3				
10 Is there documentation of smoking habits and history of alcohol or substance abuse (age 14 and over)?	3				
11 Is there a pertinent history and physical exam?	4				
12 Are lab and other studies ordered, as appropriate, and reflect primary care physician review?	4				
13 Are working diagnoses consistent with findings?	4				
14 Do plans of action/treatment appear consistent with diagnosis (es)?	4				
15 Is there a date for a return visit or other follow-up plan for each encounter?	4				
16 Are problems from previous visits addressed?	3				
17 Is there evidence of appropriate use of consultants?	3				
18 Is there evidence of continuity and coordination of care between primary and specialty physicians?	4				
19 Do consultant summaries, lab and imaging study results reflect primary care physician review?	4				
20 Does the care appear to be medically appropriate?	3				
21 Is there a completed immunization record (ages 13 and under)?	4				
22 Are preventive services appropriately used?	4				
23 Are advance directives present on the chart (21 and older)?	4				
24 Does pediatric documentation include: 4 points total					

23

- Growth chart (1.5 pts)	1.5				
- Head circumference chart (1 pt.)	1				
- Developmental milestones (2.5 pts.)	1.5				
25 Is there a list of current medications?	4				
26 If a mental health problem is noted, was a referral made, or was treatment performed by the PCP?	3				
27 If a substance abuse problem is noted, was a referral made, or was treatment or education noted?	3				
TOTAL	100				

Appendix C-5* :
Excerpt from “Member Complaint Annual Summary, Plan Year XV,
October 1996 to September 1997,”
Mercy Care Plan

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

**MERCY CARE PLAN
MEMBER COMPLAINT ANNUAL SUMMARY
Plan Year XV
October 1996 to September 1997**

PURPOSE/BACKGROUND

Mercy Care Plan's member complaint program was initiated in 1992. While improvements have been made to the process over time, the basic methodology has remained the same with the exception of Plan Year XIV. As a result, Plan Year XIV data is not presented in this report. The purpose of this report is to identify problem areas and develop improvement strategies.

METHODOLOGY

A member complaint is defined as any expression of dissatisfaction reported by a member. A standardized form and coding system are used to document and categorize a complaint (*see Appendix I*).

Complaints are initially reviewed by Member Services and categorized as service or clinical. These categories are sub-categorized to assist in identifying issues for development of improvement strategies. The Member Services Supervisor reviews each complaint to ensure coding accuracy.

Upon completion of follow-up activities, an outcome code is assigned. Three outcomes are possible: (1) the complaint is not verified; (2) the complaint is verified; or (3) a different issue is identified.

FINDINGS

Less than 1% of members reported a complaint during Plan Year XV. This is not surprising given that 97% of members responding to the Member Satisfaction Survey report being satisfied with the Health Plan.

Complaints Related to Service

Service complaints account for 63% of all member complaints. Consistent with previous years' findings, communication, accessibility, and transportation issues remain the top reasons for service complaints. Communication and accessibility issues are also the top service reasons given for physician changes.

Table I

SERVICE ISSUES	PLAN YEAR		
	<i>XII</i>	<i>XIII</i>	<i>XV</i>
	% of all Complaints	% of all Complaints	% of all Complaints
Communication	22%	20%	24%
Accessibility	27%	40%	16%
Transportation	11%	11%	16%
All Others	NA	NA	7%
TOTAL	49%	60%	63%

For a complete table, refer to Appendix II, Table I.

As shown in *Table I* above, member complaints related to communication issues have remained relatively constant over the past three (3) years, while accessibility issues have significantly decreased. Despite complaints about accessibility, 92% of members responding to the Member Satisfaction Survey report being seen by their primary care physician during the past year and 94% were satisfied with their physician.

Transportation complaints increased between Plan Year XIII and XV. According to data from the Member Satisfaction Survey, only 5% of members report using taxi services during a given year, yet transportation accounts for 16% of all complaints. An internal Transportation Task Force has made many attempts to improve services in this area. To date, none have been very effective. The Health Plan is currently in the process of exploring other improvement opportunities.

Complaints Related to Clinical Care

The remaining complaints (37%) relate to clinical care, as perceived by the member. Treatment issues are the leading cause of clinical complaints as well as for physician changes. These issues usually include medical care not meeting the member’s expectations, prescriptions that are not covered, or members who are unable to see a specialist of choice. These complaints generally have no bearing on the quality of care provided. The Quality Management staff evaluate each complaint related to care. Only 6% of clinical complaints were verified.

Table II – Clinical Complaints

CLINICAL CATEGORIES (Member Perception)	<i>PY XIII</i>	<i>PY XV</i>
	% of all Complaints	% of all Complaints
Treatment Issues	23%	29.7%
Medication Issues	NA	4.7%
Inappropriate Provider Behavior	NA	2.2%
Office Environment	NA	.8%
TOTAL	23%	37%

For a complete table, refer to Appendix II, Table III and IV.

Complaints By Provider Category

Sixty-two percent (62%) of complaints are against primary care physicians. This is not unexpected since the primary care physician serves as the “gatekeeper” for the member's medical care and provides the majority of services to the member. The remaining categories (transportation, pharmacy, dental, hospitals, etc.) account for the other 38%. Please refer to *Appendix II, Table II* for additional information.

Complaints by Individual Provider

Complaints by physician are reviewed and analyzed per 1,000 members. For purposes of this report, only providers with more than 100 members are evaluated. Only three physicians are identified as having more than 50 complaints per 1,000 members, with only one appearing in multiple plan years. Complaint data by provider are further analyzed by service and clinical categories. For complete data, please see *Appendix II, Tables VI through IX*.

Service

- Three (3) physicians account for 13% of communication/relationship issues.
- Four (4) physicians account for 18% of accessibility and availability issues.
- One (1) transportation provider accounts for 86% of all transportation complaints.

Clinical

- Four physicians account for 13% of treatment issues as perceived by the member. The Quality management department follows up with these providers.

Complaints Related to County and Program

As expected, members in Maricopa and Pima counties report the majority of member complaints (see *Appendix II, Table IV*). This is mainly due to the larger number of members in these counties. Acute members account for 93% of all member complaints, while the DD members account for only 7%. It is possible that the DD Case Manager resolves member issues and they are never reported to the Health Plan. For complete data, please see *Appendix II, Tables IX through XI*.

SUMMARY

Overall, less than 1% of members reported a complaint this year, the lowest since Plan Year XI. The significance of these findings is difficult to assess as benchmark data does not exist.

For Plan Year XV, treatment issues were the leading cause of member complaints followed by communication and availability issues with primary care providers. Opportunities for improvement in these areas should be pursued.

RECOMMENDATIONS

- Re-evaluate the methodology used to work with providers reported to have communication, availability, and treatment issues.
- Attempt to develop benchmarks and establish a standard level of performance for member complaints.
- Continue to evaluate transportation alternatives and other improvements for transportation services.

Member Complaint Form

Date Received	Program	Provider
Member Name	County	Provider Telephone #
Identification Number	Caller's Name	Provider Type
Group #	Caller's Phone Number	Date of Occurrence
DOB		

SERVICE ISSUES

Accessibility and Availability Issues

- MEA1 Appointment delay time
- MEA2 Wait time in office for a scheduled appointment
- MEA3 Call back issues
- MEA4 Office hours limited
- MEA5 Telephone accessibility
- MEA6 Member unable to see doctor of choice in the office
- MEA7 Refusal to see member for not paying co-payment (MCP only]

Communication/Relationship Issues

- MER1 Courtesy of doctor
- MER2 Courtesy of staff
- MER3 Communication Concerns/Member doesn't understand directions/process
- MER4 Relationship Concerns
- MER5 Appointment scheduling error

Billing Issues

- MEH1 Member is complaining about premium billing from HCGA
- MEH2 Member is being billed and SCHN has not received the claim
- MEH3 Member being balance billed for covered, pre-approved services
- MEH4 Member required to pay for covered service

Covered Benefits

- MEB1 Non-covered Services

Administration

- MES1 Health Plan staff was rude
- MES2 Prior Authorization process
- MES3 Claims processing
- MES4 Limited choice of PCPs
- MES5 Limited choice of Specialist
- MES6 PCP/Specialist leaving the plan

Transportation Issues

- MET1 Member missed appointment due to late transportation (prescheduled)
- MET2 Transportation provider did not pick member up on time and was late to appointment, but was still seen
- MET3 Reckless driving by transportation company
- MET4 Courtesy of transportation staff
- Other

Comments:

QUALITY ISSUES

Treatment Issues

- MEL1*** Treatment did not meet member's expectations
- MEL2*** Referral issues
- MEL3*** Other

Office Environment

- MEI1** Failure of provider to wash hands
- MEI2** Failure of provider to wear gloves when performing a procedure where body fluids may be present
- MEI3** Using unclean instruments
- MEI4** Office conditions unacceptable
- MEI5*** Other

Medication Issues

- MEM1*** Member is prescribed a medication that he/she is allergic to
- MEM2*** Provider prescribes the wrong medication for the condition the member has
- MEM3*** Pharmacy dispenses the wrong dosage/type of medication
- MEM4*** Delay in calling in prescription
- MEM5*** Courtesy of Pharmacy staff
- MEM6*** Other

Inappropriate Provider Behavior

- MEE1*** Inappropriate provider behavior
- MEE2*** Other

Comments:

Follow-up action and date:

Member notified of outcome

Yes No Date _____

***Member notified of right to file a grievance**

Yes No Date _____

Staff Member: _____

Reviewed By: _____	Date: _____
Member Type: _____	Resolution Type: _____

APPENDIX I

CODING SYSTEM

**MEMBER COMPLAINTS,
PRIMARY CARE PHYSICIAN CHANGES,
AND REMARKS**

SERVICE

Availability and Accessibility

1. **MEA1** Appointment availability
2. **MEA2** Wait time in office for scheduled appointment - not more than 45 minutes to see provider
3. **MEA3** Call back issues
4. **MEA4** Office hours limited
5. **MEA5** Telephone accessibility, i.e., on hold, no answer, busy signal
6. **MEA6** Member unable to see doctor of choice in the office
7. **MEA7** Refusal to see member for not paying co-payment [MCP only]

Communication/Relationship Issues

1. **MER1** Courtesy of doctor
2. **MER2** Courtesy of staff
3. **MER3** Member doesn't understand directions/process given by PCP
4. **MER4** Relationship concerns, i. e., member feels relationship with provider is not good, i. e., refuses to see doctor again
5. **MER5** Appointment Scheduling Error

Billing Issues

1. **MEH1** Member is complaining about premium billing from HCGA
2. **MEH2** Member is being billed and SCHN has not received claim
3. **MEH3** Member being balance billed for covered pre-approved services
4. **MEH4** Member required to pay for a covered service

Covered Benefits

1. **MEB1** Non-covered services

Administration

1. **MES1** Health Plan's staff was rude
2. **MES2** Prior Authorization Process
3. **MES3** Claims process
4. **MES4** Limited choice of PCPs
5. **MES5** Limited choice of specialists
6. **MES6** PCP/Specialist leaving the plan

Transportation

1. **MET1** Member missed appointment due to late(pre-scheduled)transportation

2. **MET2** Transportation provider did not pick member up on time and was late to appointment, but was still seen.
3. **MET3** Reckless driving by transportation company
4. **MET4** Courtesy of transportation staff

CLINICAL
(follow-up completed by Quality Management)

Treatment Issues

1. **MEL1** Treatment did not meet members expectations
2. **MEL2** Referral issues

Office Environment

1. **MEI1** Failure of provider to wash hands
2. **MEI2** Failure of provider to wear gloves when performing a procedure where body fluids may be present (like suturing, vaginal exam).
3. **MEI3** Using unclean instruments
4. **MEI4** Office conditions unacceptable, ie., dirty office or examining room

Medication Issues

1. **MEM1** Member is prescribed a medication that he/she is allergic to
2. **MEM2** Provider prescribes the wrong medication for the condition member has
3. **MEM3** Pharmacy dispenses the wrong dosage/type of medication
4. **ME M4** Delay in calling in prescription (over one day after initial request)
5. **MEM5** Courtesy of Pharmacy staff

Inappropriate Provider Behavior

1. **MEE1** Inappropriate provider behavior (Provider handles or touches member inappropriately; Provider uses inappropriate language; Provider discusses a members case in a public area).

APPENDIX II

Table I

PLAN YEAR XV			
SERVICE COMPLAINTS BY SUB-CATEGORY - MEMBER PERCEPTION			
Category	# of Complaints	% of all Complaints	Per 1,000 Members
ACCESSIBILITY AND AVAILABILITY ISSUES	100	16%	1.616
A1 Appointment delay time	34	6%	0.550
A2 Wait time in office	20	3%	0.323
A3 Provider call back issues	19	3%	0.307
A4 Office hours limited	2	0%	0.032
A5 Telephone accessibility	14	2%	0.226
A6 Unable to see doctor of choice in office	7	1%	0.113
A7 Refusal to see member for not paying co-pay	4	1%	0.065
COVERED BENEFITS	16	3%	0.259
B1 Non-covered services	16	3%	0.259
BILLING ISSUES	6	1%	0.097
H1 HCGA premium billing issues	0	0%	0.000
H2 Member is being billed	1	0%	0.016
H3 Member is being balance billed	2	0%	0.032
H4 Member required to pay for covered service	3	0%	0.048
COMMUNICATION/RELATIONSHIP ISSUES	146	24%	2.360
R1 Courtesy of doctor	34	6%	0.550
R2 Courtesy of staff	27	4%	0.436
R3 Communication concerns	68	11%	1.099
R4 Relationship concerns	17	3%	0.275
R5 Appointment scheduling error	0	0%	0.000
ADMINISTRATION	15	2%	0.242
S1 Health Plan staff was rude	7	1%	0.113
S2 Prior Authorization process	7	1%	0.113
S3 Claims processing	0	0%	0.000
S4 Limited choice of PCPs	0	0%	0.000
S5 Limited choice of Specialists	0	0%	0.000
S6 PCP/Specialist leaving the plan	1	0%	0.016
TRANSPORTATION ISSUES	98	16%	1.584
T1 Member missed appointment (transportation)	45	7%	0.727
T2 Member late but still seen (transportation)	37	6%	0.598
T3 Reckless driving by transportation company	5	1%	0.081
T4 Courtesy of transportation staff	11	2%	0.178
OTHER	4	1%	0.065
TOTALS	385	63%	6.223

Appendix C-6^{*} :
**“Texas Medicaid Managed Care (STAR and STAR+PLUS) Provider
Satisfaction Survey,” Texas Department of Health**

^{*} These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

Texas Medicaid Managed Care (STAR and STAR+PLUS) Provider Satisfaction Survey

You have been selected to participate in a survey to gauge satisfaction levels with Medicaid Managed Care plans, such as STAR and STAR+PLUS, in the state of Texas. This information will be aggregated and sent to the Texas Department of Health for review. Your views are very important, and suggestions will be used to improve the program. **At no time will you be identified personally to any agency.**

When indicating your responses, consider **“very satisfied”** to mean **“I would not make major changes to Medicaid Managed Care on the issue in question”** and **“very dissatisfied”** to mean **“I have considered dropping out of Medicaid Managed Care based on the issue in question.”**

Please restrict your answers to the questions to your personal experiences within the last six months.

<p>Marking Instructions:</p>  Please fill in the bubble(s) completely.	<p>Examples:</p> Please use pencil or pen. <input type="radio"/> Right <input type="radio"/> Wrong <input type="radio"/> Wrong <input type="radio"/> Wrong
---	--

Section I. How satisfied are you with Medicaid Managed Care in the following areas related to clinical care? Please fill in one bubble only. **If you are not involved in clinical care, please proceed directly to Section II.**

1. How satisfied are you that Medicaid Managed Care provides appropriate coverage of treatment or clinical services according to nationally recognized standards of care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
2. How satisfied are you that Medicaid Managed Care provides appropriate coverage of health promotion or disease prevention according to nationally recognized standards of care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
3. How satisfied are you that Medicaid Managed Care provides appropriate reimbursement for your services?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
4. How satisfied are you with medicaid's medicaid formulary?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
5. How satisfied are you with access to consultations and specialty care with **in-network** providers by Medicaid Managed Care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
6. How satisfied are you with access to consultations and specialty care referrals to **out-of-network** providers by Medicaid Managed Care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
7. How satisfied are you with Medicaid Managed Care's utilization review procedures?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know
8. How satisfied are you with grievance procedures at the plan level in Medicaid Managed Care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know

Section II. How satisfied are you with Medicaid Managed Care in the following areas related to administration and organization? **If you do not have personal experience in one of these areas, please fill in “Not applicable.”**

9. How satisfied are you with the amount of paperwork required by Medicaid Managed Care?

Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not applicable Don't Know

Appendix C6- Satisfaction Survey

<p>10. How satisfied are you with the amount of pone work required by the plans in Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>11. How satisfied are you with the timeliness of claims/capitation payment from Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>12. How satisfied are you with the accuracy of claims/capitation payment from Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>13. How satisfied are you with the timeliness of authorizations/precertificatons from Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>14. How satisfied are you with the ease of obtaining authorizations/precertifications from Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>15. How satisfied are your with the customer services provided by Medicaid Managed Care to patients and their families?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>16. How satisfied are you with the customer service provided by Medicaid Managed Care to providers and office staff?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>17. How satisfied are you with the training provided by Medicaid Managed Care to providers and office staff?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>18. How satisfied are you with your participation in quality management or quality assurance activities?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>19. Have you used the provider manuals from the plans in Medicaid Managed Care?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>If you answered "No" or "Don't know", please skip to Section III.</p>
<p>20. How satisfied ar you with the provider manual from Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>Section III. The last set of questions related to overall feelings about Medicaid Managed Care and some basic demographics about you and the patients in your practice.</p>
<p>21. How would you rate your overall satisfaction with Medicaid Managed Care?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>22. Do you feel that Medicaid Managed Care increases, decreases, or does not affect access to care for patients?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>23. Do you feel that Medicaid Managed Care increases, decreases, or does not affect continuity of care for patients?</p> <p><input type="radio"/> Very Satisfied <input type="radio"/> Somewhat Satisfied <input type="radio"/> Neutral <input type="radio"/> Somewhat Dissatisfied <input type="radio"/> Very Dissatisfied <input type="radio"/> Not applicable <input type="radio"/> Don't Know</p>
<p>24. Do you feel that Medicaid Managed Care patients are well informed about their benefits?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>If no, please explain _____</p> <p>_____</p> <p>_____</p>
<p>25. Would you recommend participation in Medicaid Managed Care to a colleague?</p>

Yes No Don't Know
 If no, please explain

26. Which Medicaid Managed Care plan had the most influence on your responses to this survey? (Fill in only one)

Access Amerihealth Harris Methodist PCA Humana Health Plans
 ACCESS STAR+PLUS Community First HMO Blue Texas Health Network
 Americaid Community Health Choice HMO Blue STAR+PLUS Texas Health Network
 Americaid STAR+PLUS Firstcare Methodist Care (Carefirst) STAR+PLUS

27. What is your practice management type?

Group Academic Other, please specify
 Solo IPA (Individual Practice Association)

28. What type of patient care do you offer?

Primary Care Combined
 Specialty Health-related services (ie. Home health, durable medical equipment, etc.)

29. What is your primary billing type with Medicaid Managed Care?

Fee for Service Capitation Case rate Combinations Other, please specify

30. How long have you been involved with Medicaid Managed Care in Texas?

Less than six months Six months to 1 year More than 1 year

31. Approximately what percentage of the patients in your practice are enrolled in Medicaid Managed Care?

Less than 24% 25 – 49% 50 – 74% 74 – 100%

32. What is your occupation?

Primary Care Physician (MD, DO)
 Specialty Care Physician (please specify specialty)
 Psychiatrist
 Psychologist
 Nurse Practitioner
 Nurse
 Administrator/Manager
 Office Staff (such as receptionists, billing clerks, etc.)
 Pharmacist
 Physical/Occupational Therapist
 Social Worker/Counselor
 Other, please specify

33. Are you a behavioral health provider (part of a BHO)?

Yes No

34. How many years have you been in practice?

Less than one year 4-6 years 10 years or more
 1-3 years 7-9 years

35. For future reference, which method would you prefer to use in the responding to Texas Department of Health– sponsored surveys?

- Telephone interview
- E-mail form
- Mail-in survey
- electronic response via secured URL (web-site)
- other (please specify)

**THANK YOU VERY MUCH FOR YOUR PARTICIPATION.
Please place your completed survey in the postage paid envelope provided.**

Appendix C-7* :
“MMCD Policy Letter 99-01 Regarding
Community Advisory Committees, April 1999,”
California Health & Human Services Agency,
Department of Health Services

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

April 2, 1999

MMCD Policy Letter 99-01

TO: [X] County Organized Health Systems Plans
[X] Geographic Managed Care Plans
[X] Prepaid Health Plans
[X] Primary Care Case Management Plans
[X] Two-Plan Model Plans

SUBJECT: COMMUNITY ADVISORY COMMITTEE

PURPOSE

This policy letter provides clarification regarding the contract responsibilities of Medi-Cal managed care plans (hereafter referred to as Plans) in implementing and maintaining community linkages through the formation of a Community Advisory Committee (CAC). It applies only to Plans with this contract requirement.

POLICY

Plans with the contract requirement of implementing and maintaining a CAC must demonstrate the participation of consumers, community advocates, and traditional and safety-net providers in the CAC. The Plan must establish the CAC as one of the essential methodologies for gathering cultural and linguistic information from its stakeholders and the community that it serves. The Plan must ensure the committee's responsibilities include advising on cultural competency issues, and on educational and operational issues affecting groups who speak a primary language other than English.

I. Membership

The CAC membership and representation must be reflective of the Medi-Cal population in the Plan's service area. The Plan must make a good faith effort to include representatives from hard-to-reach populations, e.g., members with physical disabilities.

The Plan must modify the CAC membership as the beneficiary population changes.

II. Function

The CAC's function is to provide information, advice, and recommendations to the Plan on educational and operational issues with respect to the administration of the Plan's cultural and linguistics services program. These advisory functions shall include, but are not limited to, providing input on the following:

1. Culturally appropriate service or program design.
2. Priorities for health education and outreach program. Member satisfaction survey results.
4. Findings of health education and cultural and linguistic group needs assessment.
5. Plan marketing materials and campaigns.
6. Communication of needs for provider network development and assessment.
7. Community resources and information.

DISCUSSION

The Plan is encouraged to provide the following support for CACS:

1. Hold regular CAC meetings and provide adequate staff support for committee activities.
2. Address barriers to participation of representatives of hard-to-reach and marginalized populations (i.e., childcare, transportation, evening meetings, convenient location, etc.).
3. Provide sufficient resources, within budgetary limitations, to support CAC activities, member outreach, retention, and support.

If you have any questions regarding this policy letter, please contact your contract manager.

Appendix C-8* :
“MMCD Policy Letter 99-03 Regarding
Linguistic Services, April 1999,”
California Health & Human Services Agency,
Department of Health Services

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

April 2, 1999

MMCD Policy Letter 99-03

TO: [X] County Organized Health Systems Plans
[X] Geographic Managed Care Plans
[X] Prepaid Health Plans
[X] Primary Care Case Management Plans
[X] Two-Plan Model Plans

SUBJECT: LINGUISTIC SERVICES

PURPOSE

This policy letter provides clarification regarding Medi-Cal managed care plans' (hereafter referred to as Plans) contract requirements relative to the provision of cultural and linguistic services.

GOAL

To assure the limited English proficient (LEP) Medi-Cal Plan members equal access to health care services through the provision of high quality interpreter and linguistic services.

POLICY

1. Civil Rights Act of 1964

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, all Plans must ensure that all Medi-Cal LEP members have equal access to all health care services.

To comply with the Civil Rights Act of 1964, all Plans must develop and implement policies and procedures for ensuring access to interpreter services for all LEP members. (all LEP members mean all members who are limited English proficient, including those who speak a language other than one of the threshold languages defined below.) The Plan's procedures must include ensuring compliance of the subcontracted providers to these requirements. An option for ensuring subcontractors' compliance is via their subcontracts. In addition, Plan's procedures must ensure that LEP members will not be subjected to unreasonable delays in receiving appropriate interpreter services when the need for such services is identified by the provider or requested by the LEP member.

Interpreter services must be available on a 24-hour basis. This can be accomplished by on-site interpreters or by assigning a LEP member to a physician able to provide services in the member's language. In addition, Plans may employ bilingual or multilingual membership staff who can interpret for providers or use contracted community-based organization for interpreter services. If these face-to-face services are not feasible, Plans may use the telephone language lines for interpreter services. The intent of the contractual requirement is not to have Plans rely solely on telephone language lines for interpreter services. Rather, telephone interpreter services should supplement face-to-face interpreter services, which is a more effective means of communication.

Plans must not require, or suggest to LEP members, that they must provide their own interpreters. The use of family, friends, and particularly minors, may compromise the reliability of medical information. LEP members may be reluctant to reveal personal and confidential information to family members, friends or minors. In addition, family, friends and minors are not trained in interpretation skills. Use of such persons could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. In a medical setting, reluctance or failure to reveal critical personal information could have serious, even life threatening, health consequences. In addition, family, friends and minors may not be competent to act as interpreters, since they may lack familiarity with specialized terminology. However, a family member or friend may be used as an interpreter if this is requested by the LEP individual after being informed he/she has the right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality. Plans must ensure that their providers document the request or refusal of language/interpreter services by a LEP member in the medical record.

II. Threshold Languages

Threshold languages in each county are designated by the Department of Health Services, These are primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes, are also considered threshold languages for a county.

Plans with threshold language requirements must provide the following:

1. Interpreter services at key points of contact (medical and nonmedical) for members whose language proficiency is in one of the threshold languages. Medical points of contact include face-to-face or telephone encounters with providers (physicians, physician extenders, registered nurses, pharmacist, or other personnel) who provide medical or health care advice

to members. Plans are encouraged to maintain a provider network (at a minimum, primary care providers) with sufficient number of bilingual and multilingual providers and provider staff who speak some of the threshold languages. Plans must list the language capabilities of these providers in their network directories (see Policy Letter 98-12). Plans must also ensure access to interpreter services at all network pharmacy sites during pharmacy service hours. At a minimum, telephone interpreter services must be available in the threshold languages if requested by a LEP member for pharmacy counseling on drug dosages, drug interactions, contraindications, adverse reactions, etc.

Nonmedical points of contacts include membership services, appointment services, and member orientation sessions.

2. Procedures for referring members to culturally and linguistically appropriate services. Plans must ensure that network providers are aware of these services.
3. Signage and written materials which have been translated into threshold languages.

III. Assessing and Monitoring Effectiveness of Linguistic Services

Some Plans have the following contract requirements:

1. "Assess, identify, and report the linguistic capabilities of interpreters or bilingual health plan and contracted staff."
2. "Develop and implement standards and performance requirements for the provision of linguistic services and monitor the performance of the individuals who provide linguistic services."

Plans with these contract requirements must implement procedures to monitor the language capability of providers listed in the provider directory as speaking specific languages. At a minimum, there must be documentation of whether it is the provider or the office staff who has the language skill(s), and this information must be updated at least annually. Plans must also implement performance requirements for interpreters. At a minimum, Plans must develop procedures for assessing interpreters' capabilities. These may include, but are not limited to, the following:

1. Written or oral assessment of bilingual skills.
2. Documentation of the number of years of employment the individual has as an interpreter and/or translator.
3. Documentation of successful completion of a specific type of interpreter training programs (i.e., medical, legal, court, semi-technical, etc.).
4. Other reasonable alternative documentation of interpreter capability.

Plans must also continuously evaluate the effectiveness of its linguistic services program. Plans' review and monitoring of its linguistic services must have a

direct link to the Plans' quality improvement processes. Procedures for continuous evaluation of the effectiveness of linguistic services may include, but are not limited to, analysis of grievances and complaint logs regarding communication or language problems and assessment of member satisfaction with the quality and availability of interpreter services.

Plans are strongly encouraged to centralize the coordination and monitoring of linguistic services within one department or by a coordinator. This coordinator or department would oversee the educational program(s) developed for Plan staff, providers, and provider staff on interpreter services, implementation of bilingual proficiency guidelines, and the coordination and monitoring of interpreter services.

IV. Member Informing

All Plans must inform their members of the availability of linguistic services. At a minimum, the membership material must include information regarding the member's right to:

1. Interpreter services at no charge when accessing health care. For example, at the time appointments with primary care providers are made, interpreter services should be offered to LEP patients.
2. Not use friends or family members as interpreters, unless specifically requested by the member. The Plan or plan provider must document member's refusal to accept the services of a qualified interpreter.
3. Request face-to-face or telephone interpreter services during discussions of complex medical information such as diagnoses of complex medical conditions and accompanying proposed treatment options-, explanations of complicated plans of care or discussions of complex procedures.
4. Receive informing documents translated into threshold languages (Refer to Translation of Written Informing Materials, MMCD Policy Letter 99-04).
5. File grievances or complaints if linguistic needs are not met.

DISCUSSION

Guidelines for Determining Bilingual Proficiency

Plans are encouraged to use the following guidelines for ensuring appropriate bilingual proficiency in nonmedical and medical settings. These guidelines apply to both on-site and telephone interpretation.

- Nonmedical Key Points of Contact

It is important for persons providing interpretation in nonmedical environments to have conversational fluency in both the target language and English. This

includes speaking in a grammatically correct manner for statements and questions, comprehension of spoken language related to both health care settings and Plan member services. Adequate vocabulary includes fluent use and accurate pronunciation of managed care terminology, forms of address, greetings, directions, time of day, days of the week, names of the months, Plan services process, and personnel. Nonmedical interpreters are able to assist limited English proficient members to complete forms, in English, appropriate to the specific setting or circumstance. Individuals interpreting in nonmedical settings should also be able to precisely explain nonclinical consent forms (transfer of medical records, admission forms, advance directives).

- **Medical Key Points of Contact**

Persons providing language services at medical points of contact should have all of the language skills required of those who interpret at nonmedical points of contact listed above, as well as proficiency related to clinical settings. Persons who interpret in medical settings should be fluent in medical terminology in both languages (anatomical terms, body processes and physiology, symptoms, common disease names and processes, common etiologic terms, clinical procedures, instructions, and treatment plans). These persons should have the appropriate training to take or assist with gathering information for an accurate medical history; they should also be able to assist providers by interpreting clinically related consent forms.

Guidelines for Plans' Staff and Providers' Education

It is important for the Plan managers, staff, and providers to participate in a cultural and linguistic education and awareness program. Such a program provides an understanding of the role of skilled interpretation in the provision of high quality health care services to LEP members. It enhances the Plan's ability to meet the cultural and linguistic contract requirements and serves to remind network providers of their obligation to bridge communication gaps. Quality interpreter services provided in a culturally competent manner enhances the ability of the members to comply with treatment programs, thereby enhancing the potential for good outcomes and reducing the potential for legal liabilities. Educational programs may be implemented through newsletters, one-on-one instruction, the provider manual, workshops, or other methods as determined by the Plan.

The educational and informational program may include, but is not limited to, the following:

1. The Department of Health and Human Service's Guidance Memorandum on Title VI Prohibition Against National Origin Discrimination--Persons with Limited-English Proficiency (Enclosure 1).
2. Information on Plan and provider legal vulnerability with respect to

- inadequate provision of interpreter services. The National Health Law Institute's report on "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities," 1998, Executive Summary (Enclosure 11).
3. Senate Bill 1840 amended the Section 1259, Health and Safety Code, (Enclosure III).
 4. A list of resources to assist medical interpreters (e.g., glossaries and dictionaries).
 5. Information on appropriate skills for persons who interpret, e.g., medical terminology, interactive skills, ethics related to confidentiality, and accuracy.
 6. Lists of training and testing resources for maintaining and enhancing interpreter skills.
 7. Tips or training for providers on how to work effectively with interpreters.

If you have any questions regarding this policy letter, please contact your contract manager.

Appendix C-9* :
“MMCD Policy Letter 99-04 Regarding
Translation of Written Informing Materials, April 1999,”
California Health & Human Services Agency,
Department of Health Services

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

April 2, 1999

MMCD Policy Letter 99-04

TO: [X] County Organized Health System Plans
[X] Geographic Managed Care Plans
[XI] Prepaid Health Plans
[X] Primary Care Case Management Plans
[X] Two-Plan Model Plans

SUBJECT: TRANSLATION OF WRITTEN INFORMING MATERIALS

PURPOSE

This policy letter provides clarification regarding Medi-Cal managed care plans' (hereafter referred to as Plans) contract responsibilities in providing quality translation of written informing materials to members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards. It also provides recommended guidelines on what constitutes a quality translation process for plan-developed informing materials. This policy letter applies only to Plans with these contract responsibilities.

POLICY

Plans must provide translated informing materials in the threshold languages determined by the Department of Health Services (DHS) for the county in which the Plan is operating. Plans are strongly encouraged to use the standardized process described below to ensure the consistent production of well translated materials for its members.

I. Documents Requiring Translation

Some Plans have the following contract requirements: "The Contractor will provide the following services to those Member groups (who meet numeric threshold or concentration standards) with translated written materials."

Written informing documents provide essential information to all members regarding access to, and usage of Plan services. The following written informing documents require translation into threshold languages:

1. Evidence of Coverage Booklet, and/or Member Services Guide, and Disclosure Forms. The contents of these documents include, but are not limited to, the following information:
 - a. Enrollment and disenrollment information.
 - b. Information regarding the use of health plan services, including access to after-hours emergency, and urgent care services.

- c. Access and availability of linguistic services.
- d. Primary care provider (PCP) selection, auto-assignment, and instructions for transferring to a different PCP.
- e. Process for accessing covered services requiring prior authorizations.
- f. Process for filing grievance and fair hearing.
2. Provider listings or directories.
3. Marketing materials.
4. Form letters (denial letters, emergency room follow-up).
5. Plan-generated preventive health reminders (appointments and immunization reminders, initial health examination notices, and prenatal care follow-up).
6. Member surveys.
7. Newsletters.

II. Timelines

Existing State-approved English versions of the above listed documents must be available in threshold and concentration standard languages within 180 days of the issuance of this policy letter. Plans must translate all newly developed informing documents listed above into threshold languages within 90 days after the English version is approved by the State. Although DHS does not approve the translations, the Plan must submit the finalized translations to DHS prior to using these documents.

III. Plan Members Receiving Translated Materials

The Plan must implement procedures to identify members whose primary language is a threshold language. Sources for identification of limited English proficient members include the Medi-Cal Enrollment Data Set (MEDS), health plan enrollment data, initial health assessments, or other databases generated by the health plan. The Plan must implement procedures for sending these members translated materials on a routine basis.

DISCUSSION

Quality Translation

Plans are strongly encouraged to use the Translation Process described below to produce well-translated informing documents. The translation process begins when DHS or another state agency (e.g., the Department of Corporations) approves the finalized English version of the source document. Translated documents must be available within three months from the date the State approves the English version.

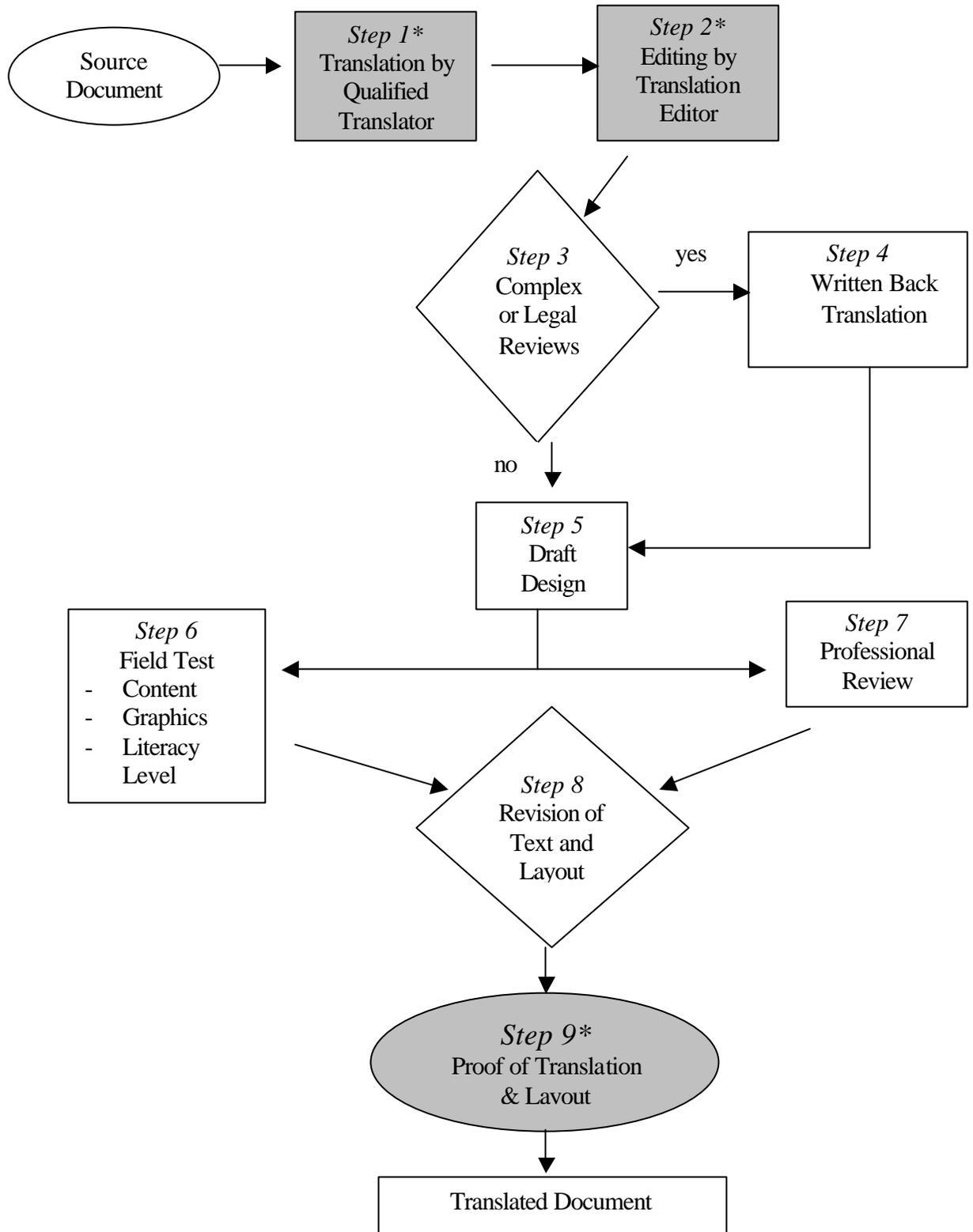
If the Plan contracts with an outside translation vendor, the Plan is strongly

encouraged to ensure that a quality-control process as described below is used by the vendor. The Translation Process Flow Chart (Enclosure I) explains the process for producing culturally and linguistically appropriate translation. The Flow Chart Instructions delineate the steps needed to translate a source document to the target language (Enclosure II). The definitions for the terms used in the Flow Chart are in Enclosure III.

The use of different Qualified Translators is essential during several stages of the translation process to ensure accuracy, completeness, and reliability of the translated material. Back translations are critical for complex or legal documents (i.e., Evidence of Coverage booklet, release forms, or agreements). Back translation ensures accuracy and completeness by requiring that a translator, not involved in the original translation process, translate the document back into its source language for comparison and accuracy.

If you have any questions regarding this policy letter, please contact your contract manager.

Translation Process Flowchart



TRANSLATION PROCESS FLOWCHART INSTRUCTIONS

Using the Translation Process Flowchart

Choosing the correct steps depends on the document to be translated. The steps that are bolded are mandatory.

- Steps 1 & 2 By using two different qualified translators (one to translate and the other to edit), the quality of the translation will be enhanced, the risk of error will be reduced, and the diversity within a culture will be considered. It is recommended that familiarity with the regional language variations and cultural diversity of the intended audience be considered in the selection of the translation team. Word processing may be done by the Qualified Translator, Translation editor, or a word processor. Depending upon the target language and the number of translation process steps that are needed and used, word processing may take place at any point along the process.
- Step 3: Complex and legal documents require a more intensive review.
- Step 4: If it has been determined in Step 3 that the document is a complex or legal document, then a back translation is mandatory.
- Step 5: A pre-field test version of the document is rendered and proofed, including layout and graphics.
- Step 6: During field testing, the document is tested with members of the intended audience. It serves a four-fold purpose:
- 1 . To ensure that the document conveys the desired message to the intended audience;
 2. To ensure that the literacy level is appropriate for the intended audience;
 3. To allow correction of inaccuracies and misconceptions; and
 4. Identify and correct geographical or regional differences in language.
- Step 7: During professional review the document is sent to health professionals and experts who are literate in both English and the target language, familiar with the content areas, and with the intended audience.
- Step 8: The results of steps 7 and 8 are incorporated into the document. Revisions to the source document may be made to address problematic issues uncovered during the field test and professional review.
- Step 9: The combined layout and revised text are proofread.

DEFINITIONS OF TERMS IN THE TRANSLATION PROCESS

QUALIFIED TRANSLATOR

- Formal education in the target language. Ability to read, write, and understand the target language.
- Ability to read and understand the source language.
- Knowledge and experience with culture(s) of the intended audience.
- Health and managed care background is recommended.

TRANSLATION EDITOR

- A translator other than the original "Qualified Translator."
- Formal education in the target language. Ability to read, write, and understand the target language.
- Knowledge and experience with culture(s) of the intended audience.
- Ensures the translation conveys all source document information (grammar, flow, completeness, accuracy, punctuation, spelling, accents/diacritical marks, etc.).
- Health and managed care background is recommended.

PROOFREADER

- A Qualified Translator other than the translator who did the word-processing, desktop publishing, or typesetting. May be performed by the Qualified Translator or Translation Editor as long as this individual did not perform the word processing, desktop publishing, typesetting.
- Formal education in the target language. Ability to read, write, and understand the target language.
- Responsible for punctuation, spelling, accents/diacritical marks, and typographical errors.

PROFESSIONAL REVIEWER

- Experience with health care and topic of the document.
- Knowledge and experience with culture(s) of the intended audience.
- Ability to read and understand the target language.
- Direct experience working with intended audience.
- Knowledge of managed care preferred.

FIELD TESTING

- Conducted with a minimum of seven end-users per language.
- Field test coordinator--experience with health education materials development.
- Must keep documentation of process, data, and results of each field test on file,
- Process may include individual interviews, surveys, and focus groups.
- Field test should examine word choices, clarity of concept conveyed, cultural appropriateness, acceptability, appeal, literacy, graphic appeal, and appropriateness.

BACK TRANSLATION

- Conducted by a Qualified Translator other than the original translator, editor, and proofreader.
- Written translations from target language to source language.
- For legal documents to ensure accuracy and completeness.

Appendix C-10* :
“MMCD All Plan Letter 99005 Regarding
Cultural Competency, April 1999,”
California Health & Human Services Agency,
Department of Health Services

* These are reasonable facsimiles of the original documents submitted by the interviewees. They are not exact replicas and do not necessarily contain all original information.

April 2, 1999

MMCD All Plan Letter 99005

TO: Medi-Cal Managed Care Health Plans

SUBJECT: CULTURAL COMPETENCY IN HEALTH CARE--MEETING THE NEEDS OF A CULTURALLY AND LINGUISTICALLY DIVERSE POPULATION

Medi-Cal managed care plans' (hereafter referred to as Plans) attainment of cultural competency is a dynamic and evolving process. This letter presents guidelines to assist Plans in building systems that meet the needs of culturally and linguistically diverse populations. The Plan is encouraged to demonstrate continual progress towards the attainment of a high level of organizational cultural competency that is conducive to improved health care access and service delivery for its members,

DEFINITION OF CULTURAL COMPETENCY IN HEALTH CARE

Culture is comprised of a group's learned patterns of behavior, values, norms, and practices. Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided. Development and incorporation of these interpersonal and intracultural skills should effect a positive change in the manner in which health care is delivered to culturally diverse health plan members. Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

In the health care industry, cultural competency requires seven essential elements that are reflected organizationally as follows:

1. An unbiased attitude and organizational policy that values and respects cultural diversity; respect for the multifaceted nature and individuality of people.
2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illnesses and diseases, as well as differing, communication patterns.
3. Recognition of diversity among health plan members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual

- orientation, social and historical context, generational, and acculturation status).
4. Skills to communicate effectively with diverse populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care.
 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability.
 6. Programs and policies that address the health needs of diverse populations.
 7. Ongoing, program and service delivery evaluation with regard to cultural and linguistic needs of the Plan members.

GUIDELINES FOR PLAN ADMINISTRATIVE IMPLEMENTATION

All health care staff, regardless of their cultural or professional training and background, may carry a lifetime of learning (i.e., perceptions, attitudes, and ideas) of diverse cultural groups. These perceptions and attitudes may or may not be conducive to furthering their knowledge about how to interact and effectively treat health plan members seen on a daily basis. If these attitudes and perceptions present barriers to effective communication and treatment of culturally and linguistically diverse populations, the Plan is encouraged to train the health plan staff and health care professionals to overcome negative stereotypes and generalizations. This training must receive support from the highest level of administration. To ensure clarity regarding the importance of cultural competency, the Plan is encouraged to incorporate the following components in policies and procedures and in establishing performance measures and incentives:

1. Include cultural competency in the Plan mission.
2. Encourage community input and advisement on relevant issues.
3. Develop a process for evaluating and determining the need for special initiatives regarding cultural competency.
4. Include recruitment and retention of staffing that are reflective and/or responsive to community, needs.
5. Continually assess the cultural competence of the Plan providers.
6. Designate staff for coordinating and facilitating the integration of cultural competency guidelines.
7. Establish an array of communication tools for distributing information to staff.
8. Participate with government, community, and educational institutions in matters related to best practices in cultural competency.
9. Establish an information system capable of identifying and profiling culturally or ethnically specific patient data.
10. Evaluate the effectiveness of strategies for improving the health status of culturally diverse populations.

GUIDELINES FOR TRAINING AND EDUCATION

I. Staff and Provider Orientation

Plans are strongly encouraged to provide orientation and training on cultural competency to staff and providers serving Medi-Cal members. The objective would be to teach participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Medi-Cal members. The orientation program will provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices.

II. Ongoing Staff and Provider Education and Training

Plans are encouraged to implement a comprehensive and ongoing staff and provider (both medical and nonmedical) education program. To be effective, the program should accommodate different learning styles and strategies to promote motivation and incentives to integrate concepts into practice and behavior change. In addition, the program should include components that allow for observation, assessment, and evaluation. The education and training program may include, but is not limited to, the following components:

1. Skills and practices regarding culture-related health care issues of primary member populations, not limited to threshold populations.
2. Concepts of cultural competency; its effects on quality care and access to care.
3. Translation of written informing documents.
4. Provision of appropriate qualified interpreters.
5. Referrals to culturally and linguistically appropriate community services.

III. Ongoing Evaluation and Feedback for Cultural Competency Education and Training Programs

The Plan is encouraged to conduct ongoing evaluation of its cultural competency education and training program by using the following strategies:

1. Identify, opportunities for education and training based on analysis of health outcomes impacted by cultural and linguistic issues.
2. Specifically address deficiencies found in cultural competency of health care delivery with educational solutions.
3. Institute methods to utilize and network with community-based organizations for appraisal of educational efforts.
4. Involve community leadership and decision-makers in the design and development of education evaluation programs.

Sources from these ongoing evaluations may include: encounter data analyses;

feedback from members, staff and providers; self-assessments; and outside audits.

IV. Sharing and Exchange of Educational Resources

The Plan is encouraged to share and exchange education resources throughout their organization with other Plans and community organizations.

V. Dissemination of Information

The Plan is encouraged to develop a system of communication to ensure coordination and dissemination of cultural and linguistic information and activities at all levels of the organization and its subcontractors.

THE RELATIONSHIP BETWEEN CULTURAL COMPETENCY AND PLAN QUALITY IMPROVEMENT PROGRAM

The Plan is encouraged to develop quality improvement (QI) projects pertaining to cultural needs of Plans' membership. These projects may assist the Plan in refining its health care services to achieve the optimum quality of care for its culturally diverse membership. QI is a continuous feedback loop comprised of assessment, measurement, reporting, and intervention. The purpose of quality improvement, as it is related to cultural and linguistic services, is to continuously improve service delivery and quality of care for specific ethnic populations. The QI process provides essential information to health care providers and consumers about the effectiveness and appropriateness of health plan's cultural and linguistic services. Incorporating components of cultural competency into the QI program allows consumers to determine whether a health plan meets their cultural and linguistic needs, and will provide the health plans with indicators to assist them in developing and implementing strategies to further refine health plan operations and quality of care.

The Plan is encouraged to institute the following:

1. Cultural and linguistic services evaluation within ongoing QI programs (see Appendix A).
2. Evaluation of members' grievances and complaints regarding cultural and linguistic issues.
3. Evaluations of members' satisfaction regarding culturally competent care.
4. Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural and linguistic standards.
5. Methods to identify health care needs of ethnically diverse membership, and conduct studies to monitor the effectiveness of health care services.
6. Provision of information on Plan's quality of care upon request to Medi-Cal members in a format that is easily understood.

If you have any questions regarding this all plan letter, please contact your contract manager.

**Appendix D:
Network Adequacy Worksheet**

New Standard <i>(List regulation, etc.)</i>
Source:
Current Standard <i>(List any similar existing standards, if any)</i>
Source:
Possible Performance Measure(s) <i>(Determine how the standard should be measured)</i>
Possible Performance Levels <i>(Define performance levels)</i>
Full Compliance:
Substantial Compliance:
Non-Compliance:
Not Applicable:
Possible Assessment Methods <i>(List possible assessment methods, if any)</i>
Interventions <i>(List possible interventions, if any)</i>

Appendix E* :
Summary of Key BBA-
Proposed Regulations Sec. 438.306

* For the purposes of this project, the “key” BBA-proposed regulations are those from Sec. 438.306 that relate to network adequacy as defined for this project. This table is a summary based on the BBA-proposed regulations appearing in the Federal Register, 42 CFR Part 400, September 1998.

Key BBA Proposed Regulations Sec. 438.306	Reference
Section 1932(c)(1)(A)(i) of the Act, as added by section 4704 of the BBA, requires State agencies that contract with MCOs under section 1903(m) of the Act to develop a quality assessment and improvement strategy that includes standards for access to care so that all covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services capacity.	Proposed BBA Rules, Section 438.306 (a)
Under proposed Sec. 438.306 (c), if an MCO contract does not cover all services under the State plan, the State agency must arrange for those services to be made available from other sources and instruct all enrollees on where and how to obtain them, including how transportation is provided.	Proposed BBA Rules, Section 438.306 (c)
In Sec. 438.306 (d), we propose new requirements, pursuant to section 1932 (c) (1) (B) of the Act and in accordance with the requirements in section 1932 (c) (1) (A) (i) of the Act, to ensure that all covered services under a contract are available and accessible to enrollees.	Proposed BBA Rules, Section 438.306 (d)
In Sec. 438.306 (d) (1), we propose that the State agency require all MCOs to maintain and monitor a network of appropriate providers that is supported by written arrangements and is sufficient to provide adequate access to covered services.	Proposed BBA Rules, Section 438.306 (d) (1)
...we propose that the State agency set its own standards for MCOs serving specific areas and populations within its State, and that the State agency ensure that those Statewide standards are met by all MCOs with which it contracts.	Proposed BBA Rules, Section 438.306 (d) (1)
The State agency's review should focus on the MCO's service planning and on the organization's basic assumptions for determining that its network is ready to serve Medicaid enrollees in a given area.	Proposed BBA Rules, Section 438.306 (d) (1)
We propose in Sec. 438.306 (d)(1)(i) and (d)(1)(ii) that the State agency's assessment ensure that the MCO's network reflects the anticipated enrollment in the MCO, with particular attention to children and pregnant women, and the expected utilization of services. This includes the aggregate number of providers needed, and their distribution among different specialties; keeping in mind that numbers and types will vary according to the MCO's projected population in terms of age, disability, and prevalence of certain conditions.	Proposed BBA Rules, Section 438.306 (d) (1) (i) and (d) (1) (ii)
Under Sec. 438.306 (d) (1) (iii), and (d) (1) (iv), the State agency's assessment must ensure that each MCO take into consideration the numbers and types of providers needed to furnish contracted services and the number of providers who are not accepting new patients.	Proposed BBA Rules, Section 438.306 (d) (1) (iii), and (d) (1) (iv)
If more than one type of provider is qualified to furnish a particular item or service, the State agency should ensure that the MCO's standards define the types of providers to be used, and ensure that those standards are consistent with State laws requiring such organizations, when applicable, to make specific types of providers available. Simple count of providers, or even providers reportedly accepting new patients are insufficient to establish capacity. Rather, the assessment of capacity necessarily should consider the volume of services being furnished to patients other than the MCO's enrollees.	Proposed BBA Rules, Section 438.306 (d) (1) (iii), and (d) (1) (iv)
In terms of assessing geographic access, we propose in Sec. 438.306 (d) (1) (v) that the State agency ensure that the MCO's network is structured in a way that considers the geographic location of providers and enrollees, including such factors as distance, travel time, and the means of transportation normally used by enrollees. In addition, we propose with this requirement that State agencies and MCOs take into consideration the physical access of facilities for enrollees with disabilities.	Proposed BBA Rules, Section 438.306 (d) (1) (v)

Appendix E- BBA Proposed Regulations

Key BBA Proposed Regulations Sec. 438.306	Reference
In Sec. 438.306 (d) (2), we are proposing that the State agency be required to ensure that MCOs allow women direct access to a women's health specialist within the MCO's network for women's routine and preventive services.	Proposed BBA Rules, Section 438.306 (d) (2)
In Sec. 438.306 (d) (3), we are proposing that the State agency ensure the MCO, if seeking an expansion of its service area, demonstrate that it has sufficient numbers and types of providers to meet the anticipated additional volume and type of services the added enrollee population may require.	Proposed BBA Rules, Section 438.306 (d) (3)
In Sec. 438.306 (d) (4), we are proposing that the State agency ensure each MCO demonstrates that its providers are credentialed as described in Sec. 438.314. We propose this paragraph to apply to all providers, including subcontracted providers.	Proposed BBA Rules, Section 438.306 (d) (4)
In Sec. 438.306 (d) (5), we are proposing that, when medically appropriate, the State agency ensure that each MCO make services available and accessible 24 hours a day, 7 days a week. This applies, at a minimum, (1) to emergency services and post-stabilization services, and (2) to non-emergency services that are required immediately because of an unforeseen illness.	Proposed BBA Rules, Section 438.306 (d) (5)
In Sec. 438.306 (d) (6), we are proposing that the State agency require MCOs to ensure that provider hours of operation are convenient to enrollees and do not discriminate against Medicaid enrollees...the State agency should ensure that the MCO assess[es] the needs of the population it proposes to enroll and require that the MCO's network have hours of operation that meet those needs.	Proposed BBA Rules, Section 438.306 (d) (6)
In Sec. 438.306 (e), we are proposing requirements, consistent with section 1932 (c) (1) (A) (I) of the Act, to require State agencies to ensure that all MCOs comply with the requirements of this section, governing the provision of services.	Proposed BBA Rules, Section 438.306 (e) (1)
In Sec. 438.306 (e) (1) (i), we are proposing that the State agency require each MCO to meet, and require its providers to meet, State-established standards, required under proposed Sec. 438.304(f) as part of the State's quality strategy, for timely access to care and member services, taking into account the urgency of need for services. Under this requirement, the State agency should ensure that the MCO establish criteria for the classification of requests for services by level of urgency and should take into consideration in-office waiting times for each type of service, the immediacy of member needs, and common waiting times for comparable services in the community.	Proposed BBA Rules, Section 438.306 (e) (1) (i)
In Sec. 438.306 (e) (1) (ii) and (e) (1) (iii), we are proposing that the State agency require the MCO to establish mechanisms to ensure compliance, and monitor continuously for compliance...The MCO's work in this area should evaluate access and availability for all services the organization is responsible for providing under its contract.	Proposed BBA Rules, Section 438.306 (e) (1) (ii) and (e) (1) (iii)
We also propose in Sec. 438.306 (e) (1) (iv) that the State agency should ensure that each MCO take corrective action if there is failure to comply. With this requirement, the State agency should ensure that the MCO not only initiates a corrective action plan, but also includes a process for assessing the effectiveness of the corrective action.	Proposed BBA Rules, Section 438.306 (e) (1) (iv)
Incorporated in all four provisions of Sec. 438.306 (e) (1) is the affirmative requirement that MCOs make affiliated providers aware of the timeliness standards and have in place mechanisms for complying.	Proposed BBA Rules, Section 438.306 (e)

Key BBA Proposed Regulations Sec. 438.306	Reference
<p>In Sec. 438.306 (e) (2), we are proposing that the MCO must provide an initial assessment of each enrollee's health: (1) within 90 days of the effective date of enrollment for each enrollee, and (2) within some shorter period of time, specified by the State agency, for pregnant women and enrollees with complex and serious medical conditions.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (2)</p>
<p>In Sec. 438.306 (e) (3), we propose that the State agency ensure that MCOs have procedures in place that have been approved by the State agency, so that the MCO: (1) timely identifies and furnishes care to pregnant women; (2) timely identifies individuals with complex and serious medical conditions, assesses the conditions identified and identifies appropriate medical procedures to address and monitor them; and (3) implements treatment plans that: are appropriate for the conditions identified and assessed in Sec. 438.306 (e) (3) (ii), are for a specified time period, specify an adequate number of direct access visits to specialists as required by the plan, and are updated periodically by the physician responsible for overall coordination of the enrollee's health...Our intent, ... is to ensure that, under BBA authority, Medicaid enrollees with complex and serious medical conditions have the ability to directly access specialist within the network for an adequate number of visits under a plan of treatment.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (3) and (e) (3) (ii)</p>
<p>In Sec. 438.306 (e) (4), we are proposing that the State agency ensure that each MCO provide services in a culturally competent manner, including at least satisfying the language requirements in Sec. 438.10 (b).</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>
<p>State agencies should ensure that MCOs identify significant sub-populations within their enrolled population that may experience special barriers in accessing health services such as the homeless or enrollees who are part of a culture with norms and practices that may affect their interaction with the mainstream health care system.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>
<p>State agencies should require MCOs to give racial and ethnic minority concerns full attention throughout the care process, and extending afterwards when care is evaluated.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>
<p>Translation services must be made available when language barriers exist, including the use of sign interpreters for persons with hearing impairments and the use of Braille for persons with impaired vision.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>
<p>For each racial or ethnic minority group, the MCO's network should include an adequate number of providers, commensurate with the population enrolled, who are aware of the values, beliefs, traditions, customs, and parenting styles of the community.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>
<p>Cultural competence requires network providers to have knowledge of medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served.</p>	<p>Proposed BBA Rules, Section 438.306 (e) (4)</p>

Appendix F* :
QISMC Domain 3- Health Services Management

* This excerpt from QISMC was downloaded from HCFA's website, www.hcfa.gov.

Guidelines for Implementing and Monitoring Compliance
with Interim QISMC Standards
Domain 3: Health Services Management
Health Care Financing Administration
September 28, 1998

3.1 Availability and Accessibility. The organization ensures that all covered services, including additional or supplemental services contracted for by or on behalf of Medicare or Medicaid enrollees, are available and accessible.

3.1.1 The organization maintains and monitors a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services and to meet the needs of the population served.

3.1.1.1 Primary care providers. The organization offers a panel of primary care providers from which the enrollee may select a personal primary care provider.

3.1.1.2 Specialists. The organization provides or arranges for necessary specialty care, including women's health services. The organization allows women direct access to a women's health specialist (e.g., gynecologist, certified nurse mid wife) within the network for women's routine and preventive health care services while the organization maintains a primary care provider or some other means for continuity of care.

3.1.1.3 Complex needs. The organization has procedures approved by HCFA (for Medicare) or the State Medicaid agency (for Medicaid) for: the identification of individuals with complex or serious medical conditions; an assessment of those conditions; the identification of medical procedures to address and/or monitor the conditions; and a treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. Also, treatment plans are time-specific and updated periodically by the primary care provider.

3.1.1.4 A Medicare organization informs beneficiaries of their right to maintain access to specialists in the case of an involuntary termination of the organization or specialist(s) for a reason other than for cause. Also, a Medicare organization provides the names of other organizations in the area that contract with the specialists of the beneficiary's choice and an explanation of the process required for the beneficiary to return to original Medicare.

3.1.2 The organization determines that all providers are qualified through the process established under standard 3.5.

3.1.3 When medically necessary, the organization makes services available 24 hours a day, 7 days a week.

3.1.4 The organization ensures that the hours of operation of its providers are convenient to and do not discriminate against enrollees.

3.1.5 The organization ensures that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities.

3.1.6 An established organization seeking an expansion of its service area demonstrates that the numbers and types of providers available to enrollees are sufficient to meet the projected needs of the population and area to be served.

3.1.7 The organization establishes--

3.1.7.1 Standards for timeliness of access to care and member services that meet or exceed such standards as may be established by HCFA (for Medicare) or the State Medicaid agency (for Medicaid), continuously monitors its provider network's compliance with these standards, and takes corrective action as necessary.

3.1.7.2 Policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management, that allow for individual medical necessity determinations.

3.1.7.3 A policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

3.2 Continuity and Coordination of Care. The organization ensures continuity and coordination of care through:

3.2.1 Use of a health care professional who is formally designated as having primary responsibility for coordinating the enrollee's overall health care;

3.2.1.1 The organization's policies specify whether services are coordinated by the enrollee's primary care provider or through some other means;

3.2.1.2 Regardless of the mechanism adopted for coordination of services, the organization ensures that each enrollee has an ongoing source of primary care.

3.2.2 Programs for coordination of care that include coordination of services with community and social services generally available through contracting or noncontracting providers in the area served by the organization.

3.2.3 Procedures for timely communication of clinical information among providers, as specified in standard 3.6;

3.2.4 Measures to ensure that enrollees: are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens.

3.3 Service Authorization

3.3.1 The organization implements written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services.

3.3.1.1 The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services.

3.3.1.2 Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence or a consensus of relevant health care professionals, and are regularly updated.

3.3.1.3 Mechanisms are in place to ensure consistent application of review criteria and compatible decisions.

3.3.1.4 A clinical peer reviews all decisions to deny authorization on grounds of medical appropriateness.

3.3.1.5 The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established under standard 2.4.3. The notice to the enrollee must be in writing.

3.3.1.6 Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services.

3.3.1.7 The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process.

3.3.1.8 Mechanisms are in effect to detect both under utilization and over utilization of services.

3.3.2 The organization furnishes information to all affiliated providers about enrollee benefits.

3.4 Practice Guidelines and New Technology

3.4.1 The organization adopts and disseminates practice guidelines.

3.4.1.1 Guidelines are based on reasonable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with contracting health care professionals, and are reviewed and updated periodically.

3.4.1.2 Guidelines, including any admission, continued stay, and discharge criteria used by the organization, are communicated to all providers and enrollees when appropriate, and to individual enrollees when requested.

3.4.1.3 Decisions with respect to utilization management, enrollee education, coverage of services, and other areas to which the guidelines are applicable are consistent with the guidelines.

3.4.2 The organization implements written policies and procedures for evaluating new medical technologies and new uses of existing technologies.

3.4.2.1 The evaluations take into account coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and federal and state Medicaid coverage decisions, as appropriate.

3.5 Provider Qualification and Selection. The organization implements a documented process for selection and retention of affiliated providers.

3.5.1 For physicians and other licensed health care professionals, including members of physician groups, the process includes:

3.5.1.1 Procedures for initial credentialing, including: a written application, verification of licensure and other information from primary sources, disciplinary status, eligibility

for payment under Medicare and Medicaid, and site visits as appropriate. The application is signed, dated and includes an attestation by the applicant of the correctness and completeness of the application.

3.5.1.2 Procedures for recredentialing, at least every two years, through a process that updates information obtained in initial credentialing and considers performance indicators such as those collected through the QAPI program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the organization.

3.5.1.3 A process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing of individual health care professionals.

3.5.1.4 Written policies and procedures for suspending or terminating affiliation with a contracting health care professional, including an appeals process.

3.5.1.5 Formal selection and retention criteria that do not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

3.5.2 For each institutional provider or supplier, the organization determines, and redetermines at specified intervals, that the provider or supplier:

3.5.2.1 Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirements;

3.5.2.2 Is reviewed and approved by an appropriate accrediting body or is determined by the organization to meet standards established by the organization itself; and

3.5.2.3 In the case of a provider or supplier providing services to Medicare enrollees, is approved for participation in Medicare. (Note: This requirement does not apply to providers of additional or supplemental services for which Medicare has no approval standards.)

3.5.3 The organization notifies licensing and/or disciplinary bodies or other appropriate authorities when a health care professional's or institutional provider or supplier's affiliation is suspended or terminated because of quality deficiencies.

3.5.4 The organization ensures compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid.

3.6 Enrollee Health Records and Communication of Clinical Information. The organization implements appropriate policies and procedures to ensure that the organization and its providers have the information required for effective and continuous patient care and for quality review, and conducts an ongoing program to monitor compliance with those policies and procedures.

3.6.1 The organization ensures that an initial assessment of each enrollee's health care needs is completed within 90 days of the effective date of enrollment.

3.6.2 The organization ensures that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that takes into account professional standards.

3.6.2.1 The organization enforces standards for health record content and organization, including specifications of basic information to be included in each health record.

3.6.2.2 The organization implements a process to assess and improve the content, legibility, organization, and completeness of enrollee health records.

3.6.2.3 Enrollee health records are available and accessible to the organization and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints.

3.6.3 The organization ensures appropriate and confidential exchange of information among providers, such that:

3.6.3.1 A provider making a referral transmits necessary information to the provider receiving the referral;

3.6.3.2 A provider furnishing a referral service reports appropriate information to the referring provider;

3.6.3.3 Providers request information from other treating providers as necessary to provide care;

3.6.3.4 If the organization offers a point-of-service benefit or other benefit providing coverage of services by non-network providers, the organization transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider; and

3.6.3.5 When an enrollee chooses a new primary care provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.

3.6.4 The organization has policies and procedures for sharing enrollee information with any organization with which the enrollee may subsequently enroll.

¹ As is noted under standard 3.1.1, there is no requirement that practitioners be board certified. However, certification must be verified if the organization intends to represent, in its enrollee literature or otherwise, that its practitioners are certified.

Appendix G: Bibliography

Appendix C-4- Medical Record Audit

“Access/Quality/Cost – Minority Health Care: Opening Doors to Access.” American Health Line 7 Oct. 1998.

Center of Health Policy Research, Enrollment Eligibility-related Duties.

Families USA Foundation. A Guide to Access Providers in Medicaid Managed Care. Jan. 1998.

Gold, Marsha. “Making Medicaid managed care research relevant.” Health Services Research 1 Feb. 1999: 1639.

Health Care Financing Administration. Department of Health and Human Services: Part III. Federal Register, 42 CFR Part 400, et al. Medicaid Program; Medicaid Managed Care; Proposed Rule. Vol. 63. No. 188, Sept. 1998.

Health Care Financing Administration. Medicaid Recipients of Medical Care by Race/Ethnicity and By State: Fiscal Year 1997. Health Care Financing Administration, 1999, <http://www.hcfa.gov/medicaid/MCD97T24.htm>.

Health Care Financing Administration. Medicaid Managed Care State Enrollment, June 30, 1997. HCFA, April 1999, <http://www.hcfa.gov/medicaid/mcsten97.htm>.

Health Care Financing Administration. QISMC: Guidelines for Implementing and Monitoring Compliance with Interim QISMC Standards; Domain 3: Health Services Management. Sept.1998.

The Interstudy Competitive Edge 8.2, Part I: HMO Directory. Bloomington, Minnesota, Sept. 1998.

“Iowa Crafting Unique Report Care, Uses Quality to Reward Contracts.” Managed Medicare & Medicaid 12 Dec. 1998.

Kim, Howard. “Managing diversity.” American Medical News 25 Jan. 1999.

National Committee for Quality Assurance. Accreditation '99 Standards. Draft 1999 NCOA Standards for MCOs, 1998.

National Committee for Quality Assurance. HEDIS/3.0, 1998.

National Committee for Quality Assurance. Medicaid HEDIS. An Adaptation of NCOA's Health Plan Employer Data and Information Set 2.0/2.5, Dec. 1995.

Schulte, Jeanne. “Questing for quality: QISMC-ly cutting the QAPI.” Healthcare Financial Management 1 Oct. 1998: 32.

Toohey, Megan, Haslanger, Kathryn, and Fagan, Alicia. Inside Medicaid Managed Care Contracts In New York City: An Analysis of Plan Contracts and Related Documents Feb. 1999.

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