

**DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS
CAL MEDICCONNECT SURVEY**

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 27, 2015 Technical Assistance Guide renders all other versions obsolete.

ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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Requirement AA-001: The Health Plan ensures timely access and availability of all covered Medicaid-based services for Cal MediConnect Enrollees.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the state to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.10.2.3. For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below.

2.10.2.3.3. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.

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2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.5. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

2.11.2.1. Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

2.11.2.1.3. **Waiting Times:** Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in 2.9.2.6.1.1. appointments, above.

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for afterhours calls.

Coordinated Care Initiative Memorandum of Understanding

c. Network Adequacy –Medi-Cal standards shall be utilized for long term services and supports, as described below, or for other services for which Medi-Cal is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medi-Cal standards are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medi-Cal standards.

California has developed transition requirements that specify continuation of existing providers (see section V). Both the State and CMS will monitor access to services through survey, utilization, and complaints data to assess needs to Participating Plan network corrective actions. Participating Plans are responsible for access to services for beneficiaries. In addition to these protections, minimum LTSS standards for Participating Plans are below. CMS and the State will

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monitor access to care and the prevalence of needs indicated through enrollee assessments, and, based on those findings, may require that Participating Plans initiate further network expansion over the course of the Demonstration.

i. Specifically, CMS and the state will require that Participating Plans:

- Meet enrollees' needs by contracting with a sufficient number of health facilities and providers that comply with applicable state and Federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.
- Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and Internet web site, upon request.
- Maintain an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area, per applicable Federal and state rules.
- Contract with safety net and traditional providers, as defined state regulations, to ensure access to care and services.
- Employ care managers directly or contract with care management organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

ii. Medi-Cal standards require the following:

- IHSS: Prime Contractor Plan Plans are required to have an IHSS Memorandum of Understanding (IHSS MOU) or contract with their respective county social services agency regarding the provision of IHSS for their enrollees. The agreement will address topics including, but not limited to:
 1. County eligibility assessment and authorization of IHSS hours.
 2. Coordination of IHSS delivery with other Participating Plan covered benefits
 3. Provider enrollment
 4. Background checks and registry services
 5. Data sharing

Prime Contractor Plans must have a contract with the Department of Social Services to address topics including, but not limited to:

1. Pay wages to IHSS providers and perform provider payroll obligations and related technical assistance.
2. Share beneficiary and provider data. Data shall be provided and shared between county agencies, Participating Plans, and State Department of Social Services, as appropriate under state law and applicable beneficiary protections.
3. Establish a referral process, care coordination team processes, and other coordination that needs to be established or enhanced to promote the integration of the IHSS Program into managed care. As discussed under section V.B describing supplemental and flexible benefits, the State will work with the Participating Plans and counties to develop a process for administration and oversight of additional personal care hours.

iii. Nursing facility: At their discretion, and according to state policy set forth regarding Demonstration plan readiness, Participating Plans may contract with licensed and certified nursing facilities, to access all levels of care in covered zip codes of the Demonstration and, to the extent possible, in adjacent zip code areas. Given the continuity of care provisions, it is unlikely enrollees will be required under the Demonstration to change facilities for the first 12 months.

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iv. Multipurpose Senior Services Program (MSSP) on site services: Prime Contractor Plans must contract with all MSSP organizations in good standing with the California Department of Aging (CDA) in the covered zip codes of the Demonstration. Prime Contractor Plans must allocate to MSSP providers the same level of funding those providers would have otherwise received under their MSSP contract with CDA until March 31, 2015 or 19 months after the commencement of beneficiary enrollment into a Participating Plan, whichever is later.

v. CBAS: Prime Contractor Plans must contract with all willing, licensed, and certified CBAS centers that are located in the covered zip codes areas and in adjacent zip code areas, not more than 60 minutes driving time away from the enrollee's residence. The transportation service may only exceed 60 minutes when necessary to ensure regular and planned attendance at the CBAS center and when there is documentation in the participant's health record that there is no medical contraindication under Welfare and Institutions Code section 14550(h). If a CBAS center does not exist in the targeted zip codes, does not have service capacity, or does not have cultural competence to service specific Participating Plan enrollees, then Participating Plans must coordinate IHSS and home health care services for eligible enrollees.

Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medi-Cal (including time, distance, and/or minimum number of providers or facilities), the Participating Plans must meet the Medicare requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. California and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid beneficiaries, but will not do so in a manner that will dilute access to care for Medicare-Medicaid beneficiaries. Networks will be subject to confirmation through readiness reviews and annual reporting.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Person(s) responsible for access and availability reports
- Director of Contracting
- Director of Provider Relations
- QI Director
- Person(s) responsible for provider network management
- Person(s) responsible for contracting with first tier, downstream and related entities ("delegated entities") tasked with providing transportation
- Person(s) responsible for contracting with delegated entities tasked with analyzing health risk data or performing any health risk or care planning assessments
- Person(s) responsible for contracting with Behavioral Health providers
- Person(s) responsible for contracting with MSSP and CBAS providers
- Person(s) responsible for contracting with county agencies for the provision of IHSS services

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DOCUMENTS TO BE REVIEWED

- DHCS/DMHC Network Assessment reports, previous four quarters
- Policies and procedures on the methodology for determining access and availability
- Policies and procedures on access and availability standards
- Policies and procedures on improvement of access and availability when not adequate
- Minutes of committee meetings where access and availability reports are reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards and assures Enrollees have access and availability for LTSS such as Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) services to Cal MediConnect participants.
- Plan communications to delegated entities regarding the access and availability standards
- Plan reports on the Plan’s telephone answer and return call wait times
- Plan reports on telephone answer and return call wait times of Network Providers and wait times in Network Providers offices
- Policies and procedures on access to non-emergency medical transportation and non-medical transportation
- Policies and procedures for managing delegated entities tasked with analyzing health risk data or performing any health risk or care planning assessments

AA-001 – Key Element 1:

1. The Plan has adopted policies and procedures to ensure adequate access to Medicaid-based services for Cal MediConnect Enrollees.

Assessment Questions	Yes	No	N/A
1.1 Do policies and procedures specify that the Plan take into consideration the anticipated number of Cal MediConnect Enrollees when evaluating adequate access to Medicaid-based services? (§2.10.1.1.1.)			
1.2 Do policies and procedures specify that the Plan take into consideration the expected utilization of services, accounting for the clinical characteristics and health care needs of Cal MediConnect Enrollees when evaluating adequate access to Medicaid-based services? (§2.10.1.1.2.)			
1.3 Do policies and procedures specify that the Plan take into consideration the number and types of providers required to provide Cal MediConnect enrollees all covered Medicaid-based services when evaluating adequate access to Medicaid-based services? (§2.10.1.1.3.)			

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Assessment Questions	Yes	No	N/A
<p>1.4 Do policies and procedures specify that the Plan take into consideration the number of providers who are not accepting new customers or patients when evaluating adequate access to Medicaid-based services?</p> <p>(§2.10.1.1.4.)</p>			
<p>1.5 Do policies and procedures specify that the Plan take into consideration the geographic location of providers and Cal MediConnect enrollees accounting for distance, travel time, and mode of transportation when evaluating adequate access to covered services?</p> <p>(§2.10.1.1.5.)</p>			
<p>1.6 Do policies and procedures specify that the Plan take into consideration whether the location of a provider is physically accessible to Cal MediConnect enrollees with disabilities when evaluating adequate access to Medicaid-based services?</p> <p>(§2.10.1.1.5.)</p>			
<p>1.7 Does the Plan attempt to contract with a sufficient numbers of LTSS providers to support Cal MediConnect Enrollees?</p> <p>(§2.10.2.; §2.10.2.3.)</p>			
<p>1.8 Does the Plan contract with all MSSP organizations in good standing with the California Department of Aging within the Plan’s Service Area?</p> <p>(§2.10.2.; §2.10.2.3; §IV.c.i of Appendix 7 of MOU)</p>			
<p>1.9 Does the Plan contract with all willing, licensed and certified CBAS centers within the Plan’s Service Area or within 60 minutes driving time of the residences of all Cal MediConnect enrollees?</p> <p>(§2.10.2.; §2.10.2.3; §IV.c.v of Appendix 7 of MOU)</p>			
<p>1.10 Does the Plan attempt to contract with a sufficient number of qualified skilled nursing facilities to support Cal MediConnect Enrollees?</p> <p>(§2.10.2.; §2.10.2.3; §IV.c.iii of Appendix 7 of MOU)</p>			
<p>1.11 Do policies and procedures specify that the Plan will contract with the nearest LTSS providers outside the covered service area if the LTSS providers within the service area cannot meet the Cal MediConnect Enrollees needs?</p> <p>(§2.10.2.3.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.12 Does the Plan maintain policies and procedures related to moving residents who reside in a Nursing Facility undergoing Medicaid decertification to other licensed facilities?</p> <p>(§2.8.4.1.3.)</p>			
<p>1.13 If a CBAS center does not exist in the Plan’s service area, does not have service capacity, or does not have cultural competence to service specific Plan enrollees, does the Plan coordinate IHSS and home health care services for eligible enrollees?</p> <p>(§2.10.2.; §2.10.2.3; §IV.c.v of Appendix 7 of MOU)</p>			
<p>1.14 Do policies and procedures specify that the Plan’s Medicaid-based services providers and facilities offer hours of operation for Cal MediConnect Enrollees that are no less than the hours of operation offered to commercial Enrollees or fee-for-service Medi-Cal Enrollees?</p> <p>(§2.10.2.3.3)</p>			
<p>1.15 Does the Plan employ care managers directly or contract with care management organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members?</p> <p>(§2.10.2.; §2.10.2.3.; §IV.c.i of Appendix 7 of MOU)</p>			
<p>1.16 Does the Plan contract with a sufficient number of transportation providers to meet the non-emergency medical and non-medical transport needs of Cal MediConnect Enrollees?</p> <p>(§2.10.1.; §2.10.1.1)</p>			
<p>1.17 Does the Plan ensure that a sufficient number of Medicaid-based Behavioral Health services providers are available via the County based Behavioral Health program to meet the needs of Cal MediConnect Enrollees?</p> <p>(§2.10.1.; §2.10.1.1)</p>			
<p>1.18 Does the Plans have an IHSS Memorandum of Understanding (IHSS MOU) or contract with their respective county social services agency regarding the provision of IHSS for their enrollees that meets the requirements of § 2.10.7.5 of the three-way contract?</p> <p>(§2.10. 7.5.; §IV.c.ii of Appendix 7 of MOU)</p>			

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Assessment Questions	Yes	No	N/A
1.19 Does the Plan make a good faith effort to give written notification to Enrollees of the termination of Medicaid-based service providers, within 15 days after the termination notice? (§2.11.1.5.)			
1.20 Does the Plan ensure that there is no disruption in services provided to the Enrollee when a Medicaid-based service provider is terminated from the Plan? (§2.11.1.5.)			

AA-001 – Key Element 2:

- 2. The Plan communicates, monitors, and enforces Medicaid-Based Behavioral Health providers’ compliance with timeframe standards set forth in the three-way contract for offering appointments for Medicaid-based services and monitors other measures of provider accessibility required by the three way contract.**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan regularly communicate the appointment availability timeframe standards for Cal MediConnect Enrollees to Medicaid-based Behavioral Health service providers and facilities as specified in §2.10.3.1 and 2.10.3.2 of the three-way contract? (§2.10.3.; §2.10.3.2.)			
2.2 Does the Plan regularly monitor that the appointment availability timeframe standards for Cal MediConnect Enrollees to Medicaid-based Behavioral Health service providers and facilities as specified in §2.10.3.1 and 2.10.3.2 of the three way contract are being met? (§2.10.3.1.; §2.10.3.2.)			
2.3 If the Plan finds that the appointment availability standards for Cal MediConnect Enrollees to Medicaid-based services as specified in the three-way contract are not being met, are corrective action plans developed and implemented? (§2.10.3.)			
2.4 If the Plan finds that the appointment availability standards for Cal MediConnect Enrollees for Medicaid-based Behavioral Health services are not being met and a corrective action plan (CAP) has been implemented, does the Plan monitor the effectiveness of the CAP? (§2.10.3.)			

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Assessment Questions	Yes	No	N/A
2.5 Has the Plan developed, implemented, and maintained a procedure to monitor waiting times of Cal MediConnect Enrollees in the offices of Medicaid-based Behavioral Health services providers? (§2.11.2.1.3.)			
2.6 Has the Plan developed, implemented, and maintained a procedure to monitor Medicaid-based Behavioral Health services providers for the time between receipt of a call from a Cal MediConnect enrollee and the time the call is returned? (§2.11.2.1.3.)			
2.7 Has the Plan developed, implemented, and maintained a procedure to require that Medicaid-based Behavioral Health maintain procedures for triaging Cal MediConnect enrollee’s calls, providing telephone advice and accessing telephone interpreters? (§2.11.2.1.4.)			
2.8 Does the Plan ensure Cal MediConnect enrollees have access to an appropriately licensed Behavioral Health professional for after hours calls? (§2.11.2.1.5.)			

AA-001 - Key Element 3:

3. The Plan evaluates access to Medicaid-based services for all Cal MediConnect Enrollees at least annually.

Assessment Questions	Yes	No	N/A
3.1 Does the Plan ensure that adequate access to LTSS (excluding IHSS) for all Cal MediConnect Enrollees is evaluated at least annually? (§2.9.1.)			
3.2 Does the Plan ensure that adequate access to County-based Behavioral Health services for all Cal MediConnect Enrollees is evaluated at least annually? (§2.9.1.)			
3.3 Does the Plan ensure that adequate access to Non-Emergent Medical Transportation services for all Cal MediConnect Enrollees is evaluated at least annually? (§2.9.1.)			

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Assessment Questions	Yes	No	N/A
<p>3.4 Does the Plan ensure that adequate access to Non-Medical Transportation services for all Cal MediConnect Enrollees is evaluated at least annually?</p> <p>(§2.9.1.)</p>			
<p>3.5 Does the Plan’s annual review assess physical access at the facilities of Medicaid-based service providers (excluding CBAS and MSSP centers) to ensure physical access meets the needs of CMC enrollees?</p> <p>(§2.9.1.)</p>			
<p>3.6 Does the Plan assess Medicaid-based service providers to ensure they provide communication services for all Cal MediConnect Enrollees, including those with limited English language skills and deaf or hearing impaired?</p> <p>(§2.9.1.)</p>			
<p>3.7 Does the Plan develop action plans to address areas where inadequate access for all Cal MediConnect Enrollees is identified?</p> <p>(§2.9.1.)</p>			
<p>3.8 Does the Plan follow-up on action plans to assess the effectiveness of the actions taken?</p> <p>(§2.9.1.)</p>			

End of Requirement AA-001: The Health Plan ensures timely access and availability of all covered Medicaid-based services for Cal MediConnect Enrollees.

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Requirement AA-002: The Health Plan ensures timely access and availability to all covered Medicaid-based services for Cal MediConnect Enrollees with disabilities.

STATUTORY/REGULATORY CITATIONS

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2.9.7. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.7.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.7.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.

2.9.7.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.7.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.

2.9.10. Provider Education and Training

2.9.10.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program and the Contractor model of care.

2.9.10.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. Contractor shall ensure that Network Provider training relates to MediConnect services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status.

Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

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2.9.10.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

2.9.10.3. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

2.9.10.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs.

2.9.10.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (See Section 2.9.7.8.)

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

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2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance;

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.12. Enrollee Services

2.12.1. Enrollee Service Representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.12.1.4. Inform callers that interpreter services are free;

2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;

2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;

2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.1. Enrollees' rights and responsibilities;

2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;

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2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., state agency services) either directly or through referral or authorization;

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any adverse actions (denials); and

2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1.2.5. Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Person responsible for cultural and linguistic program
- Enrollee Services Manager
- Person(s) responsible for provider education
- Person(s) responsible for call center or call center manager
- Person(s) responsible for ADA compliance
- Director of Contracting or Provider Relations
- QI Director

DOCUMENTS TO BE REVIEWED

- Plan cultural and linguistic program description
- Plan reports on the monitoring, evaluation, and improvement of the cultural and linguistic program
- Committee minutes where actual or potential areas of improvement of the cultural and linguistic program are identified and discussed
- Documentation of any CAP implementation or other improvements for the cultural and linguistic program and any measurements of improvement
- Provider education materials/slides on compliance with communication requirements for those Enrollees who have limited English proficiency or are deaf or hearing impaired
- Provider education materials/slides on compliance with ADA regulations and disability-competent care, and disability sensitivity.
- Provider education materials/slides on Cal MediConnect policies and procedures, Enrollee rights, clinical protocols, guidelines, and cultural competency.

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- Provider directory
- Training materials for Enrollee Services staff related to diversity or disability awareness

AA-002 - Key Element 1:

1. The Plan ensures that Plan staff and providers of Medicaid-based services are adequately educated and trained to manage the special needs of Cal MediConnect Enrollees with disabilities.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan provide education to providers of Medicaid-based services regarding Plan policies and procedures, the Cal MediConnect program, and the Plan model of care? (§2.9.10.1.)			
1.2 Does the Plan ensure that training to providers of Medicaid-based services includes information on all Cal MediConnect Enrollee rights including the right to full disclosure of health care information and the right to actively participate in health care decisions? (§2.9.10.2.)			
1.3 Does the Plan ensure that training to providers of Medicaid-based services includes information about how to be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of any enrollee, including homeless or disabled enrollees? (§2.9.10.2.; §2.9.7.; §2.9.7.7.)			
1.4 Does the Plan ensure that ongoing training to providers of Medicaid-based services is conducted when deemed necessary by the Plan, CMS, or DHCS? (§2.9.10.2.)			
1.5 Does the Plan have a process to provide information related to cultural awareness and sensitivity instruction to providers on a continuing basis? (§2.9.10.2.1.)			
1.6 Does the plan ensure that providers have available interpreters/translators for those who are deaf or hearing-impaired? (§2.9.7.6.)			
1.7 Does the Plan provide cultural competency, sensitivity, or diversity training for Plan staff? (§2.9.10.4.)			

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Assessment Questions	Yes	No	N/A
<p>1.8 Does the Plan maintain a process to provide education and training for network providers regarding any changes to Cal MediConnect policies and procedures prior to the changes taking effect?</p> <p>(§2.9.10.1.; §§2.9.10.2.)</p>			
<p>1.9 Does the Plan provide disability sensitivity training for its behavioral health, MSSP, and CBAS providers as part of its provider education?</p> <p>(§2.9.10.10.; §2.9.7.8.)</p>			
<p>1.10 Does the Plan ensure that Enrollee Services Representatives and Staff are trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding Medicaid-based services?</p> <p>(§2.12.1.1.; §2.12.1.)</p>			
<p>1.11 Does the Plan ensure that Enrollee Services representatives and Staff are trained on how to access TTY services, computer-aided transcription services, video text displays, video relay services, remote interpreting services, assistive listening systems, closed caption decoders, and how to provide accessible PDF materials, and other alternative formats?</p> <p>(§2.12.1.2.; §2.12.1.; §2.12.1.8.)</p>			
<p>1.12 Does the Plan ensure that Enrollee Services representatives and Staff are trained to provide communication with Enrollees in their primary language including American Sign Language (ASL), by speaking directly or through an alternative language device or telephone translation service?</p> <p>(§2.12.1.3.; §2.12.1.)</p>			
<p>1.13 Does the Plan ensure that Enrollee Services Representatives and Staff inform Cal MediConnect enrollees that request interpreter services that those services are free?</p> <p>(§2.12.1.4.; §2.12.1.)</p>			
<p>1.14 Does the Plan ensure that Enrollee Services Representatives and Staff are trained in disability competent care and the independent living philosophy?</p> <p>(§2.12.1.9.; §2.12.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.15 Does the Plan ensure that Enrollee Services representatives and Staff are trained to provide assistance with enrollee's with cognitive impairments and to provide reasonable accommodations needed to assure effective communication and provide Cal MediConnect enrollees with a means to identify their disability?</p> <p>(§2.12.1.10.; §2.12.1.11.; §2.12.1.)</p>			
<p>1.16 Has the Plan provided to DHCS the name and job title of the individual who is responsible for ADA compliance for Cal MediConnect?</p> <p>(§2.11.1.3.)</p>			
<p>1.17 Does the Plan have a policy in place to establish and execute a work plan to achieve and maintain ADA compliance?</p> <p>(§2.11.1.3.)</p>			
<p>1.18 Does the Plan ensure that Enrollee Services representatives and Staff inform Cal MediConnect enrollees that call the plan about how to access oral interpretation services and how to obtain written materials in alternative formats?</p> <p>(§2.12.1.13.3.; §2.12.1.)</p>			

AA-002 - Key Element 2:

2. The Plan has adopted policies and procedures to ensure access and availability of covered Medicaid-based services for Cal MediConnect Enrollees with disabilities.

Assessment Questions	Yes	No	N/A
<p>2.1 Does the Plan maintain written policies and procedures on providing access to Medicaid-based services to Enrollees with disabilities?</p> <p>(§2.11.1.2.)</p>			
<p>2.2 Does the Plan ensure that Medicaid-based programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities?</p> <p>(§2.11.1.2.)</p>			
<p>2.3 Do the Plan's policies and procedures require flexibility in scheduling to accommodate the needs of the Enrollees with disabilities?</p> <p>(§2.11.1.2.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>2.4 Do the Plan’s policies and procedures require the Plan to provide interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency?</p> <p>(§2.11.1.2.2.)</p>			
<p>2.5 Does the Plan ensure that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services?</p> <p>(§2.11.1.2.3.)</p>			
<p>2.6 Does the Plan provide large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments?</p> <p>(§2.11.1.2.3.1.)</p>			
<p>2.7 Does the Plan ensure that all written materials are available in formats compatible with optical recognition software</p> <p>(§2.11.1.2.3.2.)</p>			
<p>2.8 Does the Plan provide reading services for notices and other written materials to Enrollees upon request?</p> <p>(§2.11.1.2.3.3.)</p>			
<p>2.9 Does the Plan maintain policies and procedures for assisting Enrollees in filling out forms over the telephone?</p> <p>(§2.11.1.2.3.4.)</p>			
<p>2.10 Does the Plan provide TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf?</p> <p>(§2.11.1.2.3.6.)</p>			
<p>2.11 Does the plan provide Cal MediConnect enrollees with disabilities electronic communication methods, such as email and telephone, that reasonably accommodate the disabilities of such enrollees?</p> <p>(§2.11.1.2.3.5.)</p>			
<p>2.12 Does the Plan provide reasonable accommodation for those needing individualized assistance due to a disability?</p> <p>(§2.11.1.2.3.7.)</p>			

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AA-002 - Key Element 3:

3. The Plan maintains procedures for addressing grievances or requests for assistance made by Cal MediConnect enrollees who experience difficulty accessing Medicaid-based services due to a disability

Assessment Questions	Yes	No	N/A
3.1 Does the Plan maintain a system for addressing Enrollee grievances regarding reasonable accommodations and access to Medicaid-based services under the ADA? (§2.14.2.)			
3.2 Does the Plan have policies and procedures for providing reasonable assistance in completing any grievance forms, requests for assistance or other procedural steps to address difficulties accessing Medicaid-based services due to a disability? (§2.14.2.1.2.5.)			
3.3 Does the Plan evaluate access to the grievance and appeals system for Enrollees with disabilities? (§2.14.2.)			
3.4 Does the Plan implement corrective action when problems with access to the grievance and appeals system for Enrollees with disabilities are identified? (§2.14.2.)			

End of Requirement AA-002: The Health Plan ensures timely access and availability to all covered Medicaid-based services for Cal MediConnect Enrollees with disabilities.

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Requirement AA-003: The Health Plan ensures adequate oversight of all entities to ensure adequate access and availability for Cal MediConnect Enrollees.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.9.9. Subcontracting Requirements

2.9.9.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.9.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and Title 22 CCR Section 53867 and this Contract.

2.9.9.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and state laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.9.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC Sections 14186 through 14186.4.

2.9.9.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and state financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Person(s) responsible for Enrollee access and availability reports
- Director of Contracting or Provider Relations
- QI Director
- Person responsible for cultural and linguistics program

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- Person(s) responsible for provider education
- Person(s) responsible for ADA compliance
- Person(s) responsible to oversee Enrollee health education programs

DOCUMENTS TO BE REVIEWED

- DHS/DMHC Network Assessment Reports, previous four quarters
- Policies and procedures on the methodology for determining access and availability
- Policies and procedures on access and availability standards
- Policies and procedures on improvement of access and availability when not adequate
- Minutes of committee meetings where access and availability reports are reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards and assures Enrollees have access and availability for LTSS such as Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) services to Cal MediConnect participants.
- Policies and procedures on facility hours of operation
- Plan communications to network providers regarding the access and availability standards
- Plan reports on office wait times and telephone answer and return call wait times
- Policies and procedures on access to emergency Medicaid-based Behavioral Health services
- Plan cultural and linguistics program description
- Plan reports on the monitoring, evaluation, and improvement of the cultural and linguistics program
- Committee minutes where actual or potential areas of improvement of the cultural and linguistics program are identified and discussed
- Documentation of any CAP implementation or other improvements for the cultural and linguistics program and any measurements of improvement
- Physician and other provider education materials/slides on compliance with communication requirements for those Enrollees who have limited English proficiency or are deaf or hearing impaired
- Physician and other provider education materials/slides on compliance with ADA regulations and disability-competent care, and disability sensitivity.
- Physician and other provider education materials/slides on Cal MediConnect policies and procedures, Enrollee rights, clinical protocols, guidelines, and cultural competency.
- Provider Manual and online physician and other provider reference resources
- Provider directory
- Description of the health education program and program materials
- Documents or reports on the monitoring and evaluation of the health education program
- Committee minutes where the periodic review of the health education program are discussed and any real or potential improvements are suggested

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AA-003 - Key Element 1:

1. The Plan oversees all delegated entities to ensure timely access and availability for Cal MediConnect Enrollees.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan review policies and procedures for access standards and office hours of operation for Medicaid-based service providers caring for Cal MediConnect Enrollees to ensure compliance with the Contract standards? (§2.10.2.; §2.9.9.)			
1.2 Does the Plan evaluate at least annually that all providers caring for Cal MediConnect Enrollees provide adequate access to Medicaid-based services including behavioral health, transportation, and LTSS? (§2.10.2.)			
1.3 If the Plan delegates responsibility for assessing the physical accessibility of Medicaid-based service providers , does the Plan monitor and oversee those delegated entities? (§2.10.2.; §2.9.9.)			
1.4 If a delegated entity with responsibility for monitoring access and availability finds areas of deficiency in any required aspect, does the Plan oversee the corrective action and monitor for improvement? (§2.10.2.; §2.9.9.)			

AA-003 - Key Element 2:

2. The Plan oversees all delegated entities to ensure the Medicaid-based service provider network is adequately trained to meet the special needs of Cal MediConnect Enrollees.

Assessment Questions	Yes	No	N/A
2.1 Does the Plan monitor all delegated entities to ensure compliance with the proper education of providers on the special needs of Cal MediConnect Enrollees with disabilities including disability sensitivity training? (§2.9.9.; §2.9.7.)			
2.2 Does the Plan monitor all delegated entities to ensure compliance with ADA requirements and understanding of disability-competent care? (§2.9.9.; §2.9.7.8.; §2.11.1.3.)			

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Assessment Questions	Yes	No	N/A
2.3 Does the Plan monitor all delegated entities of Medicaid-based services to ensure compliance with ADA requirements provision of reasonable accommodation? (§2.9.9.; §2.9.7.8.; §2.11.1.3.)			

End of Requirement AA-003: The Health Plan ensures adequate oversight of all entities to ensure adequate access and availability for Cal MediConnect Enrollees.