MED - Quality of Care Managed Health Care Organization and Prepaid Inpatient Health Plan Evaluations

Purpose: Ensuring that Federal requirements for Managed Care Organization includes Prepaid Inpatient Health Plan s (MCO/PIHP) contracting are met. Performing Utilization Review (UR) Quality Assurance (QA), grievance resolution, data collection, technical analysis, and reporting to MCO/PIHP providers; and assisting the Department of Human Services (DHS) in the preparation of any managed health care waivers necessary to operate the program. Ensuring the MCP/PIHP provider panel adequacy; Participating in and Federal reviews, as necessary; Reporting on appointment surveys completed by MCO/PIHP staff; Ensuring hotline and quality assurance/utilization review functions are completed by MCO/PIHP staff; Providing medical expertise for review of appeals that occur subsequent to an adverse action by the MCO/PIHP; Ensuring that providers are adequately trained and understand all UR/QA systems, grievance procedures, and grievance resolutions, through onsite review of each MCO/PIHP.

Collect and analyze data to ensure adequate system entry and data integrity of all encounter based data submitted by each MCO/PIHP.

Identification of Roles:

Program Specialist – coordinates correspondence and scheduling, collects data, and prepares data for reports on MCO/PIHP compliance to federal standards i.e. CMS protocols. Reports quality of care concerns to the Medicaid Medical Director.

Senior Director – Provides oversight to quality of care functions, analyzes evaluation data, and makes recommendations to Department Human Services policy staff regarding managed care programs.

Medicaid Medical Director (MMD) – Analyzes program data reviews and evaluates all quality of care concerns and makes recommendations to Department Human Services policy staff, provides medical consultation.

External Quality Review Team – (EQR) Team of reviewers who annually visit MCO/PIHPs to evaluate, in-depth, the MCO/PIHPs compliance to federal standards (CMS protocols). Team consists of Program Specialist, Senior Director, Medicaid Medical Director (MMD), DHS contracted Consultant, and other members as necessary.

Performance Standards:

- Submit EQR report to the DHS within 45 business days of the onsite audit of a managed care organization.

Path of Business Procedure:

Step 1: Using tools developed from the federal requirements for contracting MCO/PIHPs, the EQR team will visit each Medicaid MCO/PIHP annually.

Step 2: The program specialist will send an initial letter to the appropriate MCO/PIHP representative six months in advance of the anticipated evaluation date (MC LTR01).

a. This letter will ask for response from the MCO/PIHP regarding:
    1. Preferred dates for onsite visit.
    2. Documentation related to performance measures, performance improvement projects (PIP) (MC LTR01-att1), and compliance with federal Medicaid MCO/PIHP regulations complete review every three years, focused review each year as necessary.

b. Pre-visit questionnaire.

c. Appendix Z of the federal regulations completed every two years.

d. Logs of all member complaints, grievances, appeals, and sentinel events for the specified review timeframe.

e. Other documentation necessary for pre-visit review.

Step 3: The MCO/PIHP will have:

a. 15 days to respond to the initial letter stating satisfactory dates for the onsite visit.

b. 60 days to provide all requested information.

Step 4: Once available dates have been received from the MCO/PIHP, the program specialist will confirm dates for the onsite visit with the MCO/PIHP.

Step 5: A tentative agenda for the onsite visit will be sent to the MCO/PIHP.

Step 6: The program specialist will initiate pre-onsite review with the information submitted by the MCO/PIHP utilizing tools developed from the federal requirements for contracting MCO/PIHPs.

a. The senior director and Medicaid Medical Director (MMD) will review submitted information, as appropriate.

Step 7: Appropriate information will be forwarded to the DHS contracted consultant.

Step 8: In depth information and/or documentation will be available to the EQR team at the time of the onsite i.e., policies, procedures, manuals, reports, etc.

a. The visited MCO/PIHP will be scored, utilizing standard tools, based on compliance with federal requirements including internal quality management and improvement, utilization management, member rights and responsibilities, credentialing and recredentialing, medical records, disease prevention and health promotion services, access and availability, data integrity, and performance measures and performance improvement project (PIP) analysis and outcomes including data validation.

Step 9: The program specialist with input from the senior director, MMD, and other EQR team members, will develop notes for preliminary report of the onsite visit within 15 days of the onsite visit.

a. These notes will be submitted to the DHS contracted consultant for report creation.

Step 10: The consultant will draft the preliminary report and submit the report to DHS for submission to the MCO/PIHP.

a. The preliminary report will contain the tools, the EQR Team scores for each tool component, and observations and recommendations on findings.

b. The MCO/PIHP will be afforded a 45-day response timeframe to the preliminary report. This response will be directed to DHS.
c. DHS will forward the MCO/PIHP response to the EQR Team and Consultant.
d. Upon receipt of the MCO/PIHPs response to the preliminary report, the program specialist will review the MCO/PIHPs comments and relay additional feedback to the consultant.
e. The consultant will incorporate the MCO/PIHP response into a final evaluation report that will be forwarded to DHS policy staff, who will again forward the final report to the MCO/PIHP within 90 days of the onsite review.

RFP Reference:

6.2
6.2.8
6.2.8.1
6.2.8.2
6.2.8.3

Interfaces:

N/A

Attachments:

N/A

Forms/Reports:

MC LTR01

Date

MCO contact

Dear (contact):

The Iowa Department of Human Services (DHS) requires an external quality review organization assure an acceptable standard of care is being delivered by the licensed managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) in Iowa. The external quality review organization will conduct onsite evaluations for the MCOs/PIHPs with Iowa Medicaid members.

In order to arrange for this evaluation, please send to me by (15 days), a list of three or more dates during the month of (month of onsite) that would be convenient for your organization. During the onsite visit, the EQR Team will need to meet with the chief executive officer, medical director, quality management director, member and provider relations directors, and any other participants you think are appropriate.

The Centers for Medicare & Medicaid Services has developed, and DHS has mandated the use of, standardized external quality review activity protocols for Medicaid MCOs/PIHPs. All external quality reviews performed subsequent to March 2004 require these protocols be followed.

The EQR Team will review documentation related to performance measures, performance improvement projects, and compliance with federal Medicaid Managed Care regulations. A list of documents that should be copied and forwarded to the EQR is enclosed. Please have all documentation on the enclosed list submitted by (60 days).

The enclosed previsit questionnaire, Information System Capabilities Assessment (Appendix Z of the CMS protocols[if appropriate]), list of performance measures, and list of performance improvements projects should be completed and all requested documents returned to me by (60 days).

Along with the specified documents requested, please also include a log of all member complaints, grievances, appeals, and sentinel events. From the log submitted, the EQR Team will select random cases and ask that those complete files be available during the onsite visit.

We look forward to hearing from you regarding available dates for the visit and receiving the requested information in the timeframes specified. Please send all correspondence and requested information to Program Specialist, Iowa Medicaid Enterprise, Medical Services Unit, PO Box 36478, Des Moines, Iowa, 50315. If you have any questions you may contact me at (515) 725-XXXX, or via email to NAME@dhs.state.ia.us.

Sincerely,

NAME, Program Specialist
Iowa Medicaid Enterprise, Medical Services Unit

enclosures

cc: NAME, Iowa Department of Human Services

Attachment to MC LTR01

List of Performance Improvement Projects (PIPs)

(return documentation for each PIP separately)

Name of PIP: _____

Dates of Study period _____/_____/_____ to _____/_____/_____

Number of Medicaid enrollees in MCO _____

Number of Medicaid enrollees in PIP _____

Number of MCO enrollees in PIP _____

Number of physicians in PIP _____

Provide a description of the PIP design and implementation (i.e., selected topic, project questions, indicators, population, sampling methods, data collection, improvement strategies, and project results).

MC LTR01 Attachment 2

List of Performance Measures (PMs)

(return documentation for each PM separately)

Name of PM: _____

Dates of Study period _____/_____/_____ to _____/_____/_____

Number of Medicaid enrollees in MCO _____

Number of Medicaid enrollees in PM _____

Number of MCO enrollees in PM _____

Number of physicians in PM _____

Provide a description of the PM design and implementation (i.e., selected topic, project questions, indicators, population, sampling methods, data collection, improvement strategies, and project results).

MC LTR01 Attachment 3

PREVISIT INFORMATION - MEDICAID

Review Timeframe: _____

1. Organization Name: _____
   Street Address: _____
   City: _____ County: _____
   State: _____ Zip: _____ Telephone: _____
   Date of founding: _____ Date questionnaire completed: _____

2. Current number of enrollees: Commercial: _____
   Medicaid: _____
   Medicare: _____

	Medicaid	Commercial
3. Total number of practitioners:	_____	_____
4. Total number of providers:	_____	_____

5. Service area map by county furnished: Yes No

6. List current Accreditation(s), effective dates, status, and type:

Accreditation	Effective Dates	Status	Type

7. Name and address of Medical Director:
   Name: _____
   Address: _____
   City, State, ZIP: _____
   Telephone: ___(_____)_____

8. Designated contact person (with organization title) if other than medical director:
   Name: _____
   Title: _____
   Telephone: ___(_____)_____

9. Person completing this form:

   Name: _____

   Title: _____

   Telephone: ___(_____)_____

10. Attach copies of the quality improvement plan(s), work plan(s), and annual report(s) for the timeframe to be reviewed. If the annual report is not completed, submit all quarterly reports for this timeframe.

11. Newsletters:
    a. What was the planned distribution of the member and provider newsletters for the review timeframe?
    b. Is the member newsletter applicable to all managed care products marketed?
    c. Include copies of the member and provider newsletters distributed during the review timeframe.

12. Include a copy of all member information distributed to new members (including the member handbook).

13. Provide policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

14. Attach organizational charts that clearly display the governing body(ies) including major administrative and clinical departments and committees effective for the timeframe to be reviewed. Please include the names and titles of committee members.

15. Indicate the types of quality improvement activities/focused pattern of care studies conducted during the timeframe to be reviewed. Include a brief summary of each quality improvement project with the following: name of study, type of study (administrative or clinical), selection or development criteria timeframe of the study, sampling selection, inclusion criteria (e.g., include codes if applicable, demographics, or administrative data), baseline data, interventions or planned interventions, and remeasurement or planned remeasurement.

16. Provide a copy of the provider manual.

17. Provide a copy of sentinel events, complaints, grievances, denial and appeals policies and procedures.

18. Provide a copy of the protocols to ensure accessibility, availability, and referral of health care practitioners. Include policies that outline timeframes for members to appointment time, routine, urgent, and emergent care. Include measurement or analysis reports on service availability and accessibility (i.e., Geo accessing).

19. Provide a summary and results of the Plan's most recent client satisfaction survey.

20. Provide policies and procedures for auditing data to check the accuracy and completeness of data (internally and externally generated).

Attachment to MC LTR04

The documents requested for pre-onsite evaluation are:

- Organization strategic plan
- Administrative policies and procedures
- Quality Improvement program description
- Quality Improvement project descriptions, (including selection or development criteria, data sources, data audit results, data analysis, and reports)
- Performance Measures (including data sources, data audit results, data analysis and reports)
- Policies and procedures for researching, selecting, adopting, reviewing, updating and disseminating practice guidelines
- Enrollee handbook (enrollee rights & responsibilities)
- Enrollee health education planning and program content
- Utilization management policies and procedures
- Coverage rules and payment policies
- Policies and procedures for denial of service
- Data on claims denials
- Grievance and appeal tracking log
- Enrollee grievance and appeals policies, procedures, and data
- Enrollee satisfaction survey results
- Service availability and accessibility standards
- Any measurement or analysis reports on service availability and accessibility (i.e., Geo accessing)
- Service planning documents and provider network planning documents (e.g., geographic assessments, provider network assessment, enrollee demographic studies, population needs assessment)
- Provider directory
- Provider contract templates
- Provider manual
- Credentialing policies and procedures and committee minutes
- Information systems capability assessment (Appendix Z)
- Policies and procedures for auditing data to check the accuracy and completeness of data (internally and externally generated) (Appendix Z)
- Procedures and methodology for oversight, monitoring and review of delegated activities
- Contracts or written agreements with organizational subcontractors
- Completed evaluations of entities conducted before delegation is granted

MC LTR02

Date

MCO contact

Dear (contact):

I am writing to confirm (dates), as the dates for the external quality review Medicaid onsite evaluation visit to (MCO name). A tentative agenda is enclosed so your staff can plan to be available, if necessary, for interviews and clarification of information. An opening conference will be held at (time) a.m. on (day, date). The closing conference will be held at the end of the day on (date) to provide a summary of the Team's findings.

The Centers for Medicare & Medicaid Services has developed, and the Iowa Department of Human Services has mandated the use of standardized external quality review activity protocols for Medicaid MCOs. A tool that has been developed for use during the onsite is enclosed for your reference.

We will review documentation related to performance measures, performance improvement projects, and compliance with federal Medicaid Managed Care regulations. Please have all previously requested documentation submitted to my attention by (date).

Thank you for your cooperation. If you have any questions, please contact me at (515) XXX-XXXX, or via email to NAME@dhs.state.ia.us.

Sincerely,

NAME, Program Specialist
Iowa Medicaid Enterprise, Medical Services Unit

enclosure

cc: NAME, Iowa Department of Human Services

Attachment to MC LTR02

External Quality Review
Onsite Evaluation of (plan)
Iowa Medicaid Product
(dates)

Agenda

DAY	**DATE**	
8:30	Opening Conference	Telligen Evaluation Team Plan Staff

9:00 - 4:00	• Performance Measures
	• Performance Improvement Projects
	• BBA Compliance
	  · Health Information Systems
	  · Grievance System
	  · Credentialing and Recredentialing
	  · Practice Guidelines
	  · Coverage and Authorization of Services
	  · Enrollment and Disenrollment
	• Encounter Data Validation	

DAY	**DATE**	

8:00 - 4:00	• Performance Measures
	• Performance Improvement Projects
	• BBA Compliance
	  · Specific Rights
	  · Access/Availability
	  · Coordination and Continuity of Care
	  · Coverage and Authorization of Services
	  · Quality Assessment and Performance Improvement Program
	  · Sub-contractual Relationships and Delegation
	  · Quality Assessment and Performance Improvement Program	

4:00	Exit Conference (tentative)	Telligen Evaluation Team Plan Staff

DAY **DATE**

This day will be reserved for any unfinished review activities. If this day is necessary to complete the review, the Exit Conference will be held at the end of this review day rather than on the previous day.

*MCO, PIHP, PAHP, and PCCM has been changed to Plan

A. SPECIFIC RIGHTS*		
Subpart C Regulations: Enrollee Rights and Protections		Score
	§438.100 Enrollee rights. *General rule.* The State must ensure that each Plan has written policies regarding the enrollee rights specified in this section; and each Plan complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees. *Specific rights - Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in this section; and an enrollee of a Plan has the following rights: The right to receive information as outlined below (in accordance with §438.10): The Plan must:	
A-1	Must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.	
A-2	Make its written information available in the prevalent non-English languages in its particular service area.	
A-3	Make oral interpretation services available and make those services available free of charge to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.	
A-4	Notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.	
A-5	Written material must use easily understood language and format; and be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	
A-6	All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.	
A-7	Must provide the information at the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program and within a timeframe that enables the potential enrollee to use the information in choosing among available Plans.	
A-8	The Plan must provide the following information to all enrollees:	
a	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. For Plans this includes, at a minimum, information on primary care physicians, specialists, and hospitals.	
b	Any restrictions on the enrollee's freedom of choice among network providers.	
c	The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	
d	Procedures for obtaining benefits, including authorization requirements.	
e	The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.	
f	The extent to which, and how, after-hours and emergency coverage are provided, including what constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions (see (**§**438.114) *Emergency medical condition* at the end of this document).	

P - proficient D - developing N - do documentation n/a - not applicable

A. SPECIFIC RIGHTS (continued)		
g	The fact that prior authorization is not required for emergency services.	
h	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. (See §422.113(c) *Post-stabilization care services* at the end of this document.)	
i	The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.	
j	Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	
k	Cost sharing, if any.	
l	How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the Plan does not cover because of moral or religious objections, the Plan need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.	
m	Grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description.	
n	Advance directives.	
o	Additional information that is available upon request, including Information on the structure and operation of the Plan.	
p	Physician incentive plans.	
A-9	Be treated with respect and with due consideration for his or her dignity and privacy.	
A-10	Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.	
A-11	Participate in decisions regarding his or her health care, including the right to refuse treatment.	
A-12	Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	
A-13	An enrollee of a Plan (consistent with the scope of the Plan's contracted services) has the right to be furnished health care services.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

B. GRIEVANCE SYSTEM		
B-1	*The grievance system.* Each Plan must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.	
B-2	A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.	
B-3	The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the Plan's notice of action. Within that timeframe—	
a	The enrollee or the provider may file an appeal; and	
b	In a State that does not require exhaustion of Plan level appeals, the enrollee may request a State fair hearing.	
B-4	The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the Plan.	
B-5	The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.	
B-6	*Notice of Action:* The notice must be in writing and must meet the language and format requirements to ensure ease of understanding.	
B-7	The notice must explain the action the Plan or its contractor has taken or intends to take; the reasons for the action; the enrollee's or the provider's right to file an appeal; if the State does not require the enrollee to exhaust the Plan level appeal procedures, the enrollee's right to request a State fair hearing; the procedures for exercising the rights specified in this paragraph; the circumstances under which expedited resolution is available and how to request it; the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	
	Timing of notice. The Plan must mail the notice within the following timeframes:	
B-8	*Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the Plan receives the grievance.	
B-9	*Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the Plan receives the appeal. This timeframe may be extended (see below).	
B-10	*Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the Plan receives the appeal. This timeframe may be extended (see below).	
a	If the Plan denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution in accordance with the regulations and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.	
	The Plan may extend the timeframes by up to 14 calendar days if the enrollee requests the extension; or the Plan shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	
B-11	*Requirements following extension.* If the Plan extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.	

P - proficient D - developing N - do documentation n/a - not applicable

B. GRIEVANCE SYSTEM (continued)		
B-12	For all appeals, the Plan must provide written notice of disposition.	
a	*Content of notice of appeal resolution.* The written notice of the resolution must include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the enrollees, the right to request a State fair hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the Plan's action.	
	Handling of grievances and appeals. In handling grievances and appeals, each Plan must	
B-13	Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	
B-14	Acknowledge receipt of each grievance and appeal.	
B-15	Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding 1) an appeal of a denial that is based on lack of medical necessity; 2) a grievance regarding denial of expedited resolution of an appeal; or 3) a grievance or appeal that involves clinical issues; are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.	
B-16	*Special requirements for appeals.* The process for appeals must provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	
B-17	Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Plan must inform the enrollee of the limited time available for this in the case of expedited resolution.)	
B-18	Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.	
B-19	Include, as parties to the appeal the enrollee and his or her representative; or the legal representative of a deceased enrollee's estate.	
B-20	For notice of an expedited resolution, the Plan must also make reasonable efforts to provide oral notice.	
a	*Expedited resolution of appeals.* Each Plan must establish and maintain an expedited review process for appeals, when the Plan determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	
B-21	The Plan must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	
B-22	The Plan must provide the information specified about the grievance system to all providers and subcontractors at the time they enter into a contract.	
B-23	The State requires Plans to maintain records of grievances and appeals and must review the information as part of the State quality strategy.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

C. ACCESS/AVAILABILITY

	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.206 Availability of services. *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of Plans. *Delivery network.* The State must ensure, through its contracts that each Plan, consistent with the scope of the Plans contracted services, meets the following requirements:	
C-1	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each Plan must consider:	
	The anticipated Medicaid enrollment.	
	The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular Plan.	
	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	
	The numbers of network providers who are not accepting new Medicaid patients.	
	The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	
C-2	Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	
C-3	Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	
C-4	If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the Plan must adequately and timely cover these services out of network for the enrollee, for as long as the Plan is unable to provide them.	
C-5	Requires out-of-network providers to coordinate with the Plan with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	
	Furnishing of services. Timely access. Each Plan must:	
C-6	Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	
C-7	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	
C-8	Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	
C-9	Establish mechanisms to ensure compliance by providers.	
C-10	Monitor providers regularly to determine compliance.	
C-11	Take corrective action if there is a failure to comply.	
C-12	*Cultural considerations.* Each Plan participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

D. COORDINATION AND CONTINUITY OF CARE

	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.208 Coordination and continuity of care. *Primary care and coordination of health care services for all Plan enrollees.* Each Plan must implement procedures to deliver primary care to and coordinate health care service for all Plan enrollees. These procedures must meet State requirements and must do the following:	
D-1	Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.	
D-2	Coordinate the services the Plan furnishes to the enrollee with the services the enrollee receives from any other Plan.	
D-3	Share with other Plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.	
D-4	Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	
D-5	*Additional services for enrollees with special health care needs— Identification.* The State must implement mechanisms to identify persons with special health care needs to Plans, as those persons are defined by the State. These identification mechanisms must be specified in the State's quality improvement strategy; and may use State staff, the State's enrollment broker, or the State's Plans.	
D-6	*Assessment.* Each Plan must implement mechanisms to assess each Medicaid enrollee identified by the State and identified to the Plan by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.	
D-7	*Treatment plans.* If the State requires Plans to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved by the Plan in a timely manner, if this approval is required by the Plan; and in accord with any applicable State quality assurance and utilization review standards.	
D-8	*Direct access to specialists.* For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each Plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

E. COVERAGE AND AUTHORIZATION OF SERVICES

	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
E-1	**§438.210 Coverage and authorization of services.** *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require the Plan and its subcontractors have in place, and follow, written policies and procedures; and that the Plan have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.	
E-2	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	
E-3	*Notice of adverse action.* Each Plan must notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For Plans, the notice must meet the requirements, except that the notice to the provider need not be in writing.	
	Timeframe for decisions. Each Plan contract must provide for the following decisions and notices:	
E-4	*Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests extension; or the Plan justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.	
E-5	*Expedited authorization decisions.* For cases in which a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. The Plan may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the Plan justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.	
E-6	*Compensation for utilization management activities.* Each contract must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	
	Notes:	

F. CREDENTIALING AND RECREDENTIALING		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.214 Provider selection. ***Credentialing and recredentialing requirements.*** *General rules.* The State must ensure, that each Plan implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.	
F-1	Each Plan must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the Plan.	
F-2	*Nondiscrimination.* Plan provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	
F-3	*Excluded providers.* Plans may not employ or contract with providers excluded from participation in Federal health care programs.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

G. ENROLLMENT AND DISENROLLMENT		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.226 Enrollment and disenrollment. The State must ensure that each Plan contract complies with the following enrollment and disenrollment requirements and limitations (§438.56). *Disenrollment: Requirements and limitations. Applicability.* The provisions apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with a Plan. *Disenrollment requested by the Plan.* All Plan contracts must—	
G-1	Specify the reasons for which the Plan may request disenrollment of an enrollee;	
a	Provide that the Plan may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and	
b	Specify the methods by which the Plan assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.	
	Disenrollment requested by the enrollee. If the State chooses to limit disenrollment, Plan contracts must provide that a member may request disenrollment as follows:	
G-2	For cause, at any time.	
G-3	Without cause, at the following times:	
a	During the 90 days following the date of the recipient's initial enrollment with the Plan, or the date the State sends the recipient notice of the enrollment, whichever is later.	
b	At least once every 12 months thereafter.	
c	Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.	
d	When the State imposes the intermediate sanction. The types of intermediate sanctions that a State may impose include: civil money penalties; appointment of temporary management for a Plan; granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll; suspension of all new enrollment, including default enrollment, after the effective date of the sanction; and suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance, as well as additional areas of noncompliance. Nothing prevents State agencies from exercising that authority.	
G-4	*Request for disenrollment.* The recipient (or representative) must submit an oral or written request to the State agency (or its agent); or to the Plan, if the State permits Plans to process disenrollment requests.	

G. ENROLLMENT AND DISENROLLMENT (continued)		
G-5	*Cause for disenrollment.* The following are cause for disenrollment:	
a	The enrollee moves out of the Plan service area.	
b	The Plan does not, because of moral or religious objections, cover the service the enrollee seeks.	
c	The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.	
d	Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.	
G-6	*Timeframe for disenrollment determinations.* Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the Plan files the request.	
	Notes:	

H. SUB-CONTRACTUAL RELATIONSHIPS AND DELEGATION		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.230 Sub-contractual relationships and delegation. *General rule.* The State must ensure, through its contracts, that each Plan oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and meets the following specific conditions: before any delegation, each Plan evaluates the prospective subcontractor's ability to perform the activities to be delegated to ensure: there is a written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	
H-1	The Plan monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.	
H-2	If any Plan identifies deficiencies or areas for improvement, the Plan and the subcontractor take corrective action.	
	Notes:	

I. PRACTICE GUIDELINES		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.236 Practice guidelines. *Basic rule:* The State must ensure, through its contracts, that each Plan adopts practice guidelines that meet the following requirements:	
I-1	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	
I-2	Consider the needs of the Plan's enrollees.	
I-3	Are adopted in consultation with contracting health care professionals.	
I-4	Are reviewed and updated periodically as appropriate.	
I-5	*Dissemination of guidelines.* Each Plan disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	
I-6	*Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	
	Notes:	

J. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§438.240 Quality assessment and performance improvement program. *General rules.* The State must require, through its contracts, that each Plan have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. *Basic elements of Plan quality assessment and performance improvement programs.* At a minimum, the State must require that each Plan comply with the following requirements:	
J-1	Conduct performance improvement projects as described below. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	
a	*Performance improvement projects.* Plans must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:	
b	Measurement of performance using objective quality indicators.	
c	Implementation of system interventions to achieve improvement in quality.	
d	Evaluation of the effectiveness of the interventions.	
e	Planning and initiation of activities for increasing or sustaining improvement.	
f	Each Plan must report the status and results of each project to the State as requested, including those that incorporate the requirements. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	
J-2	Submit performance measurement data as described below.	
a	*Performance measurement.* Annually each Plan must measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements:	
b	Submit to the State, data specified by the State, that enables the State to measure the Plan's performance; or	
c	Perform a combination of the activities described in this section.	
J-3	Have in effect mechanisms to detect both under-utilization and over-utilization of services.	
J-4	Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	

P - proficient D - developing N - do documentation n/a - not applicable

J. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (continued)		
J-5	*Program review by the State.* The State must review, at least annually, the impact and effectiveness of each Plan's quality assessment and performance improvement program. The review must include—	
a	The Plan's performance on the standard measures on which it is required to report; and	
b	The results of each Plan's performance improvement projects.	
c	The State may require that a Plan have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.	
	Notes:	

K. HEALTH INFORMATION SYSTEMS		
	Subpart D Regulations: Quality Assessment and Performance Improvement	Score
	§ 438.242 Health information systems. *General rule.* The State must ensure, through its contracts, each Plan maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. *Basic elements of a health information system.* The State must require, at a minimum, that each Plan comply with the following:	
K-1	Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	
K-2	Ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.	
K-3	Make all collected data available to the State and upon request to CMS.	
	Notes:	

P - proficient D - developing N - do documentation n/a - not applicable

	Reference Only	
	§438.6(h)(i) Contract requirements. *Physician incentive plans.* Plan contracts must provide for compliance with the requirements set forth. In applying the provisions of this chapter, references to “M+C organization”, “CMS”, and “Medicare beneficiaries” must be read as references to “Plan”, “State agency” and “Medicaid recipients”, respectively. *Advance directives.* All Plan contracts must provide for compliance with the requirements of this chapter for maintaining written policies and procedures for advance directives. All Plan contracts must provide for compliance with the requirements of this chapter for maintaining written policies and procedures for advance directives if the Plan includes, in its network, any of those providers listed in this chapter. The Plan subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.	
	§438.12 Provider discrimination prohibited. *General rules.* A Plan may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If a Plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. In all contracts with health care professionals, a Plan must comply with the requirements specified. *Construction.* Paragraph (a) of this section may not be construed to require the Plan to contract with providers beyond the number necessary to meet the needs of its enrollees; preclude the Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.	
	§431.211 Advance notice. The State or local agency must mail a notice at least 10 days before the date of action, except as permitted in exceptions.	
	§431.213 Exceptions from advance notice. The agency may mail a notice not later than the date of action if the agency has factual information confirming the death of a recipient; the agency receives a clear written statement signed by a recipient that the member no longer wishes services; or gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; the recipient has been admitted to an institution where he is ineligible under the Plan for further services; the recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address; the agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; a change in the level of medical care is prescribed by the recipient's physician; the notice involves an adverse determination made with regard to the preadmission screening requirements; or the date of action will occur in less than 10 days, which provides exceptions to the 30 days notice requirements.	
	§431.214 Notice in cases of probable fraud. The agency may shorten the period of advance notice to 5 days before the date of action if the agency has facts indicating that action should be taken because of probable fraud by the recipient; and the facts have been verified, if possible, through secondary sources.	
	§431.231 Reinstatement of services. The agency may reinstate services if a recipient requests a hearing not more than 10 days after the date of action. The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy. The agency must reinstate and continue services until a decision is rendered after a hearing if action is taken without the advance notice required; the recipient requests a hearing within 10 days of the mailing of the notice of action; and the agency determines that the action resulted from other than the application of Federal or State law or policy. If a recipient's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.	

Reference Only		
	(§438.114) ***Emergency medical condition*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. *Emergency services* means covered inpatient and outpatient services that are (1) furnished by a provider that is qualified to furnish these services under this title, or (2) needed to evaluate or stabilize an emergency medical condition. *Post-stabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition. *Coverage and payment:* The following entities are responsible for coverage and payment of emergency services and post-stabilization care services: the Plan; the Plan that has a risk contract that covers these services; and the State, in the case of a Plan that has a fee-for-service contract. These entities must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Plan; and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Plan; and may not deny payment for treatment obtained under either of the following circumstances: an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of *emergency medical condition* above; a representative of the Plan instructs the enrollee to seek emergency services. The entities may not limit what constitutes an emergency medical condition, on the basis of lists of diagnoses or symptoms; and refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, Plan or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified as responsible for coverage and payment.	
	(§422.113(c)) ***Post-stabilization care services*** means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition. The M+C organization is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are pre-approved by a plan provider or other M+C organization representative; Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the M+C organization for pre-approval of further post-stabilization care services; Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if the M+C organization does not respond to a request for pre-approval within 1 hour; the M+C organization cannot be contacted; or the M+C organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the M+C organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria is met; and must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the M+C organization. The M+C organization's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care; a plan physician assumes responsibility for the enrollee's care through transfer; an M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or the enrollee is discharged.	

Subpart F Regulations: Grievance System	
§438.420 Continuation of benefits while the Plan appeal and the State fair hearing are pending. *Terminology.* As used in this section, "timely" filing means filing on or before the later of the following: within ten days of the Plan mailing the notice of action, or the intended effective date of the Plan's proposed action. *Continuation of benefits.* The Plan must continue the enrollee's benefits if the enrollee or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the enrollee requests extension of benefits.	
Duration of continued or reinstated benefits. If, at the enrollee's request, the Plan continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs: the enrollee withdraws the appeal; ten days pass after the Plan mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached; a State fair hearing officer issues a hearing decision adverse to the enrollee; or the time period or service limits of a previously authorized service has been met.	
Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the Plan's action, the Plan may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy.	
Subpart F Regulations: Grievance System	
§438.424 Effectuation of reversed appeal resolutions.	
Services not furnished while the appeal is pending. If the Plan, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.	
Services furnished while the appeal is pending. If the Plan, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Plan or the State must pay for those services, in accordance with State policy and regulations.	
Subpart D Regulations: Quality Assessment and Performance Improvement	
§438.226 Enrollment and disenrollment.	
Plan action on request. A Plan may either approve a request for disenrollment or refer the request to the State. If the Plan, or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the specified timeframes, the disenrollment is considered approved.	
State agency action on request. For a request received directly from the recipient, or one referred by the Plan, the State agency must take action to approve or disapprove the request based on the following:	
Reasons cited in the request.	
Information provided by the Plan at the agency's request.	
Any of the reasons specified in this section.	
Use of the Plan grievance procedures.	
The State agency may require that the enrollee seek redress through the Plan's grievance system before making a determination on the enrollee's request.	
The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe (no later than the first day of the second month following the month in which the enrollee files the request).	
If, as a result of the grievance process, the Plan approves the disenrollment, the State agency is not required to make a determination.	

P - proficient D - developing N - do documentation n/a - not applicable

	Subpart D Regulations: Quality Assessment and Performance Improvement (continued)	
	If the Plan or the State agency (whichever is responsible) fails to make the determination within the timeframes specified, the disenrollment is considered approved.	
	Notice and appeals. A State that restricts disenrollment under this section must take the following actions:	
	Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.	
	Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.	
	Automatic reenrollment: Contract requirement. If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.	

RFP Reference:
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:
N/A

MED - Quality of Care Managed Health Care Organization and Prepaid Inpatient Health Plan Encounter Data Validation

Purpose: Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter based data from MCO/PIHP providers.

Identification of Roles:
Project Assistant – reviews random sample of each MCO/PIHP providers to ensure accurate sampling, requests claims from MMIS, requests medical records from providers, adjudicates claims through medical record review, and reports findings to DHS policy staff.

Senior Director – provides oversight to quality of care functions and makes recommendations to DHS policy staff regarding managed care programs.

Medicaid Medical Director (MMD) – Provides medical consultation when necessary.

Performance Standard:
- Provide quarterly reports within 10 business days of the end of the reporting quarter.

Path of Business Procedure:
Step 1: The project assistant will receive a quarterly random sample of MCO/PIHP claims from DW (25 inpatient claims and 25 outpatient claims for each MCO/PIHP) when an MCO/PIHP exists.
Step 2: The project assistant will request medical records for claims selected in sample.
Step 3: The project assistant will review received medical records to adjudicate claims information.
Step 4: The project assistant will prepare a report detailing the results of the evaluation. Upon completion, the report will be forwarded to DHS policy staff on a quarterly basis within 10 business days of the end of the reporting quarter.
Step 5: The project assistant will forward quality of care concerns identified during the review to the MMD.
Step 6: The MMD will communicate concerns in writing to DHS policy staff.

Forms/Reports:

Medical Records Request Letter

DATE.....Prov ID: «ProvID»

«ProvName»
«Addr1»
«Addr2»
«City», «State» «Zip»

Dear Provider:

Iowa Medicaid Enterprise's (IME) Medical Services unit oversees the quality of care function for IME. The quality of care function is designed to monitor the care provided to Iowa Medicaid members. Medical Services focuses on the two managed care programs as the basis for this quality function. In order to validate encounter data for MCO/PIHP NAME, Medical Services is conducting an analysis to ensure adequate system entry and integrity of all the data.

A random sample of Iowa MediPASS members was selected. Encounter data reflects that services (Type is IP = inpatient, or OT = other) were provided by you for the member and dates listed below:

Type	Member ID	Member Name	**Dates of Service**
«Type»	«MbrID»	«MbrFN» «MbrLN»	«DOS1» - «DOS2»

Diagnosis from Claim: «DxCd»-«DxName»

Procedure from Claim: «ProcCd»-«ProcName»

Please copy all medical record documentation which authenticates the services received by the identified member for the identified service, and supply those records within 10 days to:

Iowa Medicaid Enterprise
Medical Services - Quality of Care FAX: (515) 725-1355
Attention: _____
PO Box 36478
Des Moines, IA 50315

Your assistance in completing this validation of encounter data is appreciated. **Complete medical records are not necessary, you need only supply documentation to support the specific procedure in question. For inpatient claims, please copy only the doctor order and results for the procedure in question.** If you have questions regarding this request you can contact me at (515) 974-_____, or toll-free 1-800-383-1173, extension 5_____.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise, Medical Services

RFP Reference:

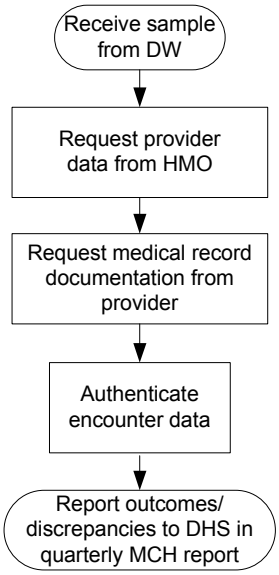
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

HMO Encounter Data Validation



MED - Quality of Care Managed Health Care Organization and Prepaid Inpatient Health Plan Appeals

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://www.dhs.state.ia.us/dhs/appeals/appeal_decision.html. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

A notice of appeal rights is provided with each notice of adverse decision. Notices of appeal rights include timeframes for filing a formal appeal. DHS requires that Medical Services not provide a formal reconsideration or first level appeal. If new information is submitted by the member or provider following the adverse decision or with the formal request for appeal, medical services' staff will review the information and decision and approve the service if medical necessity criteria are met. Additional information regarding a service that is a non-covered service will not be considered. If the requested service continues to not be supported by the submitted documentation, staff will secure additional PR. Since this is an informal process, it is not necessary to obtain a PR other than the one who made the initial decision. It is also not necessary to send a second notice of an adverse decision if the service does not meet medical necessity criteria. Upon filing a formal appeal, members or providers will be informed of the certification of the appeal by DHS Appeals Section. For specific operational procedures related to appeals completed by Medical Services on behalf of DHS. See Med Srv Policy Support Appeals at IME Universal/Operational Procedures/Medical Services.

Performance Standard:

- Performance standards are not specified for this procedure.

Forms/Reports:

Managed Care Appeal Log

Date Appeal Received	Appeal Log#	Appeal Requestor (M-Member, P-Provider)	Member Name (last, first)	Member ID	Plan	Provider	Provider ID	Plan Final Decision Date	Documentation Complete (if 'no', date addl info requested/received)			Packet to MD	Packet to Policy	Comments
									Com?	Req	Rec			
	YY-001								Y / N					
	YY - 002								Y / N					
	YY - 003								Y / N					
	YY - 004								Y / N					
	YY - 005								Y / N					
	YY - 006								Y / N					
	YY - 007								Y / N					
	YY - 008								Y / N					
	YY - 009								Y / N					
	YY - 010								Y / N					
	YY - 011								Y / N					

Managed Care Appeal Case Summary Appeal Packet

Appeal Log #:_____

Member Name: _____ Member ID: _____
Plan: _____
Provider: _____ Provider ID: _____
Denial Type: _____
Initial Denial Date: _____ Plan Appeal Date: _____

Define documentation received and identify each with attachment number to be included in appeal packet.

Attachment 1.....(i.e., appeal record from Plan, etc.)
Attachment 2.....
Attachment 3.....
Attachment 4.....
Attachment 5.....
Attachment 6.....
Attachment 7.....
Attachment 8.....

Outline dates and actions taken through Plan denial and appeal process:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

RFP Reference:

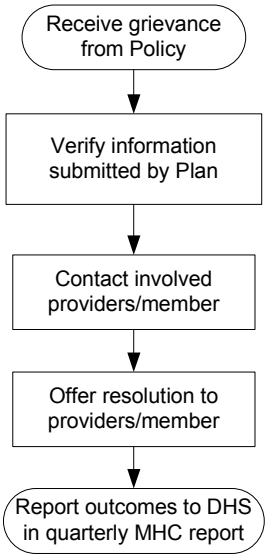
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

MCO Grievance/Appeal



MED - Quality of Care MediPASS Twenty-four Hour Coverage

Purpose: Verify compliance by MediPASS providers with requirement for 24-hour coverage for assigned Medicaid members.

Identification of Roles:

Project Assistant – will conduct telephone surveys to MediPASS patient manager after normal business hours to ensure compliance with requirements.

Senior Director – Provides oversight to quality of care functions and makes recommendations to DHS policy staff regarding managed care programs.

Medicaid Medical Director (MD) – Provides medical consultation when necessary.

Performance Standard:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The project assistant will receive from provider services the list of providers who were contacted for their Appointment Survey.
Step 2: The project assistant will conduct after-hours telephone calls to do the same MediPASS providers' offices to ensure that required information is made available to MediPASS members on a 24-hour basis.

a. Telephone calls will assess the information available to members including the availability of the provider to the member and/or coverage in the absence of the provider, and the adequacy of recorded information available to members regarding how/where to obtain emergency and/or after hours care, and/or for other providers to access the patient manager for referral inquiries.

Step 3: The project assistant will summarize findings in a report and include these findings in the Quarterly Managed Health Care report within 10 business days of the end of the reporting quarter.
Step 4: The project assistant will initiate educational letters to MediPASS providers who do not meet established standards.

a. Responses to these letters are mandated, and project assistant will confer with DHS policy staff if sufficient resolution is not apparent.

Step 5: The project assistant will initiate notification letters to MediPASS providers who met the established standards.
Step 6: The project assistant will periodically check any patient manager who is deemed non-compliant in future audits to ensure ongoing compliance.

Forms/Reports:

Appointment Survey Report

Call Month	Provider	ID	Spec	Telephone	City	ST	CO	Date of Call	24-hr Survey	Compliance Ltr Sent	Non-compliance Ltr Sent	Non-compliance response recd	Notes/Findings

Educational Letter Compliant Patient Manager

DATE

PROVIDER NAME PROVID
PROV_ADDR1
PROV_ADDR2
PROV CITY, ST ZIP

Dear MediPASS Patient Manager:

MediPASS patient managers are required to have 24-hour per day, seven day per week coverage for care/referral of members. Managed health care is part of the State plan amendment, and 24-hour coverage is mandated as a condition of participation as a MediPASS patient manager as stated in the contract (page 4, Section VII.D). Recently your name was randomly selected for monitoring of this requirement. Iowa Medicaid Enterprise Medical Services staff, under contract with the Iowa Department of Human Services, is responsible for monitoring this requirement.

A call was made to your office (**NUMBER)** after normal office hours on **DATE**, and we were pleased to find that your 24-hour coverage was appropriate. Access to medical care was available to your MediPASS patients through your automated answering machine/service, or by another appropriate means.

We understand the 24-hour requirement and the monitoring of this requirement may be an inconvenience, but it is an important element in managed health care. Your participation in the MediPASS program is greatly appreciated. If you have any questions or comments concerning this review, please feel free to contact me at (515) 974-3008

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services - Quality of Care

Educational Letter Non-compliant Patient Manager

DATE

PROVIDER NAME PROVID
PROV_ADDR1
PROV_ADDR2
PROV CITY, ST ZIP

Dear MediPASS Patient Manager:

MediPASS patient managers are required to have 24-hour per day, seven days per week coverage for care/referral of members. Managed health care is part of the State plan amendment, and 24-hour coverage is mandated as a condition of participation as a MediPASS patient manager as stated in the contract (page 4, Section VII.D). Recently your name was randomly selected for monitoring of this requirement. Iowa Medicaid Enterprise Medical Services staff, under contract with the Iowa Department of Human Services, is responsible for monitoring this requirement.

A call was made to your 24-hour number **(NUMBER)** after normal office hours on **DATE**. By calling the telephone number you have supplied for your members, information regarding how to contact the designated patient manager was not available. In managing a member's medical care, the patient manager must provide for, or arrange 24-hour, seven day per week coverage. The patient manager or designee must be available to the member because the member has no other alternative but to go to his or her MediPASS provider for non-emergency care. In addition, other providers must have the ability to contact the designated patient manager after hours in the event the member seeks treatment from a provider who is not the designated patient manager.

The system that is currently in place from your office does not afford the caller the necessary contact information after normal business hours. Please respond to me within 10 working days with any information you have to clarify this issue, or any steps taken to rectify this issue.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services - Quality of Care
(515) 974-3008

If you have additional questions concerning your MediPASS requirements, the Iowa Medicaid Enterprise Provider Services unit is available to assist you at 800-338-7909.

RFP Reference:

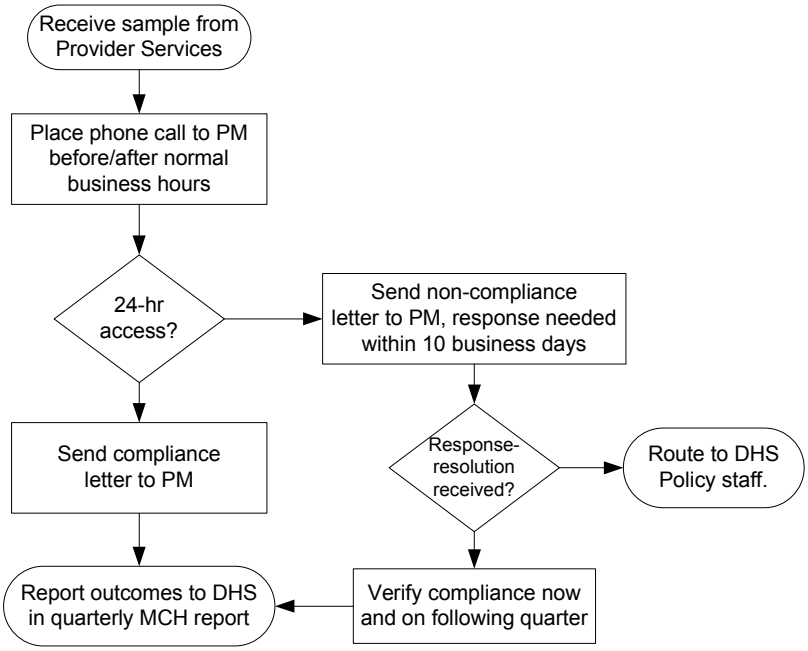
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

MediPASS 24-hour Access Survey



MED - Quality of Care MediPASS Utilization Review and Quality Assurance Reports

Purpose: Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter based data from MediPASS providers.

Identification of Roles:

Project Assistant – reviews random sample of MediPASS providers to ensure accurate sampling, requests claims from MMIS, requests medical records from patient manager s, adjudicates claims through medical record review, and reports findings to DHS policy staff.

Senior Director – provides oversight to quality of care functions and makes recommendations to DHS policy staff regarding managed care programs.

Medicaid Medical Director (MMD) – Provides medical consultation when necessary.

Performance Standard:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The project assistant will receive quarterly data from Data Warehouse (DW).
Step 2: The project assistant will create letters to be sent to the indicated patient manager coordinate the printing and mailing of the letters that will be generated for these providers.
Step 3: The project assistant will field any questions from patient manager regarding this quarterly mailing.

Forms/Reports:

Utilization Review and Quality Assurance Reports

Date: February 2008

MediPASS Patient Utilization Report
Reporting Period: October - December 2007
Average Units of Service per Enrollee Served

PM NAME
ADDR1
ADDR2
CITY, ST ZIP

ProvID

# of Enrollees: #

# of Enrollees Served: #

	Patient Manager Unit/DoI	Statewide Average Unit/DoI	GP/FP Average Unit/DoI	Int Med Average Unit/DoI	Peds Average Unit/DoI	OB/GYN Average Unit/DoI
Inpatient (discharges)	U/$	1/$3357	1/$3322	1/$3211	1/$3211	1/$2754
Outpatient	U/$	2/$389	2/$400	2/$476	2/$476	2/$331
Outpatient ER	U/$	1/$243	1/$254	1/$309	1/$309	1/$285
Home Health	U/$	1/$189	1/$214	1/$184	1/$184	0/$0
Phys Office	U/$	2/$96	2/$94	2/$95	2/$95	2/$84
Phys Surgery	U/$	1/$263	1/$264	1/$435	1/$435	2/$699
Lab/X-ray	U/$	2/$58	2/$63	2/$102	2/$102	2/$95
DME Supplies	U/$	2/$189	2/$182	2/$261	2/$261	2/$79
Other Prac	U/$	2/$123	2/$131	2/$71	2/$71	2/$67
Podiatry	U/$	2/$166	2/$163	1/$165	1/$165	0/$0

This report compares the average utilization of your members with specialty/category and statewide average utilization. Only members that received services are included in the averages. The types of services reflected on this report represent services utilized by your members for the quarter.

The first column shows your individual averages for each service category. The second column shows averages for all Patient Managers across the State, regardless of specialty/category. The remaining columns show averages for all other Patient Managers within each specialty/category.

The purpose of this utilization report is to provide you with information on the utilization of your MediPASS members. The report is not an indicator of your performance as a MediPASS Patient Manager.
If you have any questions about this report, please contact us at 1-800-383-1173, extension ____, or in Des Moines calling area at (515) 974-XXXX. Thank you for your continued participation in the MediPASS program.

Quarterly MediPASS Member Utilization Exception Report

Reporting Period: October 1 through December 31, 2007

Patient Manager: 1234567 PM Name

		Inpatient Hospital (discharges)			Outpatient Hospital (# visits)			Outpatient ER (# visits)			Home Health (# visits)			Physician Office (# visits)			Physician Surgery (# visits)			Pharmacy Claims (# drugs)			Lab/X-ray (# procedures)			DME Supplies (# supplies)			Other Practitioner (# procedures)			Chiropractic Services (# procedures)			Podiatry (# procedures)		
Mbr ID	Mbr Name	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util	Units	Avg Units	High Util
1234567A	Sue Doe	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	0	1		2	2		0	1		4	2		8	2	*	0	2		2	2		0	2		2	2		6	2	*	5	4		1	1	
4444444B	Jane Smith	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
1234567B	Jay Doesmith	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	0	1		2	2		0	1		4	2		8	2	*	0	2		2	2		0	2		2	2		6	2	*	5	4		1	1	
5555555B	Jade Doe	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
1234567C	Joseph Smith	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	0	1		2	2		0	1		4	2		8	2	*	0	2		2	2		0	2		2	2		6	2	*	5	4		1	1	
3333333B	Kay Smith	0	1		2	2		0	1		8	2	*	7	2	*	0	2		0	2		0	2		0	2		6	2	*	8	4	*	1	1	
	Prior Quarter:	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n

Report Date: February 2008

Member utilization exceptions are indicated by an asterisk (*) in the High Util column
n = data not available

RFP Reference:

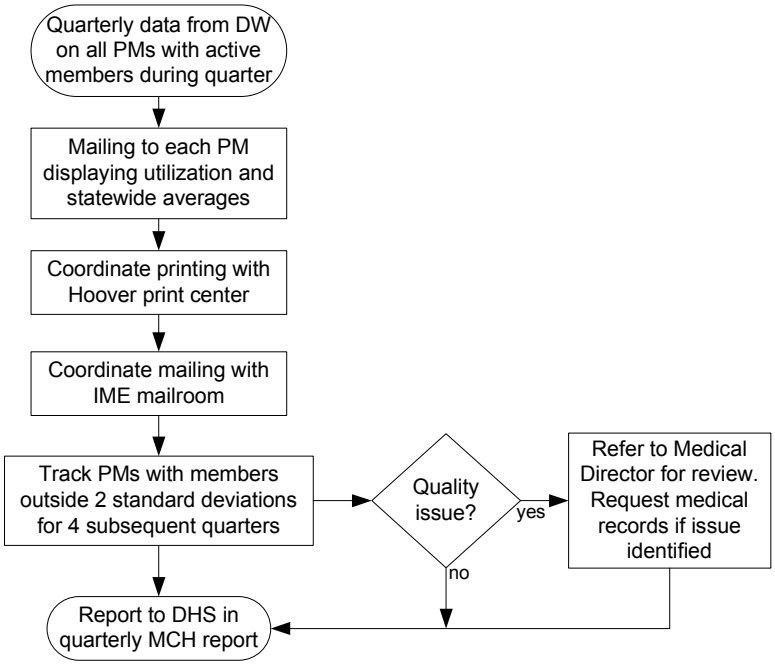
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

MediPASS Utilization and Exception Reports



MED - Quality of Care MediPASS Referral Authorization

Purpose: Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter based data from MediPASS providers.

Identification of Roles:

Project Assistant – reviews random sample of MediPASS providers to ensure accurate sampling, requests claims from MMIS, requests medical records from patient manager s, adjudicates claims through medical record review, and reports findings to DHS policy staff.

Senior Director – provides oversight to quality of care functions and makes recommendations to DHS policy staff regarding managed care programs.

Medicaid Medical Director (MMD) – provides medical consultation when necessary.

Performance Standard:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The project assistant will receive quarterly data from DW that identifies 1.25 percent of claims paid that include a referring provider number on the paid claim.
Step 2: The project assistant will create letters to be sent to the indicated patient manager to authenticate referral source.
Step 3: The project assistant will coordinate the printing and mailing of letters that will be generated from this selection.

a. The letters will request that the patient manager respond to authenticate each referral.
   1. The project assistant will generate a second notice for any patient manager that does not respond to the initial request for authentication within 10 days.
   2. Third requests will subsequently be generated for any patient manager that has not responded to the first or second request.
   3. Telephone calls will be made to any patient manager who does not respond to three written requests.

Step 3: The project assistant will generate letters to any treating providers whose referral is not authenticated by the patient manager.

a. This letter will request supporting documentation of the receipt of the referral from the patient manager.
b. Second requests will be sent to each treating provider who has not responded within 10 days.
c. Third requests will be sent within 10 days of the second request to any treating provider who has not responded.
d. Third request letter will indicate that further nonresponse will be basis for referral to SURs for recoupment of monies paid.

Step 4: The project assistant will create letters to be sent to the corresponding patient manager once referral documentation has been submitted by the treating provider.

a. A letter acknowledging receipt of this supporting documentation will also be sent to the treating provider.

Step 5: The project assistant will prepare educational letters to any treating provider that is found to have treated a MediPASS member without adequate referral from the patient manager.

a. This correspondence will include language stating that if further non-compliance with the MediPASS referral process is not followed; subsequent payments will be recouped through the Program Integrity (PI) Unit.

Step 6: The project assistant will keep a log of all educational letters sent for non-compliance, as well as a log of all subsequent PI referrals.

Step 7: The project assistant will prepare a report detailing the results of responses from both patient manager s and treating providers.

Step 8: This report will be submitted to DHS policy staff in the Quarterly Managed Health Care report on a quarterly basis within 10 business days of the end of the reporting quarter.

Step 9: The project assistant will forward quality of care concerns identified during the review to the MMD.

Step 10: The MMD will communicate concerns in writing to DHS policy staff.

Step 11: Categories of service that must either be provided or authorized by the patient manager:

a. Inpatient hospital
b. Outpatient hospital
c. Emergency room service, non-emergent care
d. Physician services (except ophthalmology)
e. Clinics
    1. Rural health centers, maternal health centers, ambulatory surgical centers, genetic consultation centers, and birthing centers
f. Laboratory
g. Radiology
h. Medical supplies and durable medical equipment
i. Other practitioners
    1. Physical therapists, audiologists, rehabilitation agencies, nurse midwives, hearing aid dealers, and nurse anesthetists does NOT include mental health providers
j. Podiatric
k. Home health

Step 12: These categories should be reviewed at each date of service for changes. Categories of service that do not require authorization by the patient manager:

a. HCBS waiver
b. Area education services
c. Skilled care
d. Intermediate care
e. Intermediate care for the mentally retarded
f. Dental services
g. Prescription drugs

h. Chiropractic
i. Ambulance
j. Family planning
k. Screening
l. Optometric
m. Ophthalmology
n. Rehabilitation/CACT
o. Lead investigation
p. Infant/toddler local education services

Forms/Reports:

Appropriate MediPASS Referral Usage

DATE

«PM_NAME»
«PM_ADD1»
«PM_ADD2»
«PM_CITY», «PM_ST» «PM_ZIP»

The Iowa Department of Human Services selects MediPASS member claims for verification that other providers are using your Patient Manager authorization number appropriately. Randomly selected claims for your MediPASS members are listed below.

Please review the services listed which were processed with your Patient Manager authorization number identified as the referral number. If you (or your designee) authorized the service, place a check in "YES". However, if you did not authorize the service, place a check in "NO".

Your Patient Manager agreement requires a response to this random survey. Your cooperation is appreciated. Please return this form via FAX or mail within 10 working days to:

Iowa Medicaid Enterprise, Medical Services - QOC
PO Box 36478
Des Moines, IA 50315
FAX: (515) 725-1355

Thank you for your continued participation in the Iowa MediPASS program. You may call 1-800-383-1173, extension ____ - or Des Moines area (515) 974-3008 if you have questions.

YES	NO				
		Treating Provider:	«TP_N1»	Specialty:	«TP_SP1»
		Member Name:	«MBR_N1»	Member ID:	«MBR_ID1»
☐	☐	Date of Service:	«MBR_DOS1»	Member DOB:	«MBR_DOB1»
		Desc. of Service:	«MBRDESC1»	Member Age:	«MBR_AGE1»
		Treating Provider:	«TP_N1»	Specialty:	«TP_SP1»
YES	NO	Member Name:	«MBR_N1»	Member ID:	«MBR_ID1»
☐	☐	Date of Service:	«MBR_DOS1»	Member DOB:	«MBR_DOB1»
		Desc. of Service:	«MBRDESC1»	Member Age:	«MBR_AGE1»
		Treating Provider:	«TP_N1»	Specialty:	«TP_SP1»
YES	NO	Member Name:	«MBR_N1»	Member ID:	«MBR_ID1»
☐	☐	Date of Service:	«MBR_DOS1»	Member DOB:	«MBR_DOB1»
		Desc. of Service:	«MBRDESC1»	Member Age:	«MBR_AGE1»
		Treating Provider:	«TP_N1»	Specialty:	«TP_SP1»
YES	NO	Member Name:	«MBR_N1»	Member ID:	«MBR_ID1»
☐	☐	Date of Service:	«MBR_DOS1»	Member DOB:	«MBR_DOB1»
		Desc. of Service:	«MBRDESC1»	Member Age:	«MBR_AGE1»
		Treating Provider:	«TP_N1»	Specialty:	«TP_SP1»
YES	NO	Member Name:	«MBR_N1»	Member ID:	«MBR_ID1»
☐	☐	Date of Service:	«MBR_DOS1»	Member DOB:	«MBR_DOB1»
		Desc. of Service:	«MBRDESC1»	Member Age:	«MBR_AGE1»

PM Office Contact Person: _____ Telephone Number: _____

Procedures Summary Letter

<DATE>

<TRT PROV NAME>
<ADD1>
<ADD2>
<TRT PROV CITY>, <TRT PROV ST> <TRT PROV ZIP>

Dear Provider:

Randomly selected paid claims are audited on a quarterly basis to verify appropriate use of MediPASS patient manager's authorization numbers.

The MediPASS Procedures Summary dated February 1990 states:

> "If an enrollee requires covered services from a provider other than the patient manager, the patient manager will (1) arrange for and refer the member to the appropriate Medicaid participating provider (2) authorize the provider to perform the needed services, and (3) monitor and coordinate all such care." (page 4)

Covered services for Managed Care include outpatient hospital services.

The services listed below were reviewed by the MediPASS patient manager whose identification number was listed as the referral number on the paid claim from your location. We have contacted the patient manager and have been informed that the service was not referred/authorized by them.

Medicaid has paid a claim to you for <MEMBER NAME>, <MEMBER ID>, for date of service <DOS>. Please submit supportive documentation that you did receive a referral from the MediPASS patient manager for this service. This supportive documentation should be sent within the ten (10) working days to:

Iowa Medicaid Enterprise, Medical Services
Attention: Quality of Care
PO Box 36478
Des Moines, IA 50315
FAX: (515) 725-1355

If you have questions regarding this request, you may contact Quality of Care at 1-800-383-1173, extension ____ - or Des Moines area (515) 974-XXXX
Thank you for your cooperation.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

Referral Authorization Letter

<DATE> THIRD and FINAL REQUEST

<TRT PROV NAME>
<ADD1>
<ADD2>
<TRT PROV CITY>, <TRT PROV ST> <TRT PROV ZIP>

Dear Provider:

On <initial letter date> a letter was sent to your patient account representative requesting supportive documentation that you received a referral from the MediPASS patient manager for <MEMBER NAME>, <MEMBER ID>, for date of service <DOS>.

A second request was also mailed on <DATE>. As of today, no response has been received from your office.

If we do not hear from you in the next 10 days, this claim will be referred to the Surveillance and Utilization Review (SUR) Unit for recoupment of the money paid to you by Medicaid. Recoupment of this money will not be based on unauthorized use of the patient manager referral number on the claim, but rather on the basis that no response was received from you after two requests.

Any supportive documentation needs to be received by our office within 10 working days to avoid referral to the SUR Unit. Please send documentation to:

Iowa Medicaid Enterprise, Medical Services
Attention: Quality of Care
PO Box 36478
Des Moines, IA 50315
FAX: (515) 725-1355

If you have questions regarding this request, you may contact Quality of Care at 1-800-383-1173, extension ____ - or Des Moines area (515) 974-XXXX
Thank you for your cooperation.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

Referral Authorization Verification Letter

<DATE>

<TRT PROV NAME>
<TRT PROV ADD1>
<TRT PROV ADD2>
<TRT PROV CITY>, <TRT PROV STATE> <TRT PROV ZIP>

Dear Provider:

Thank you for responding to the referral authorization dated <INITIAL DATE>. The documentation you provided regarding **<MEMBER NAME>**, **<MEMBER ID>**, for date of service **<DOS>** has been reviewed and appears to satisfy that the provided services were authorized. A copy of the documentation submitted for review is being sent to **<PM NAME>** for their record. If **<PM NAME>** has further comments concerning this referral, we will be in contact with you. If no further comments are received, we will consider the audit closed/resolved.

Thank you for your attention to this review and for maintaining appropriate documentation of referrals. We will continue to conduct referral authorization audits on randomly selected paid claims to verify patient manager authorization. If you have any questions regarding this review process, please do not hesitate to contact us.

Thank you again for your cooperation. If you have questions regarding this correspondence you can call 1-800-383-1173, extension ____, or (515) 974-XXXX

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

Referral Not Authorized Letter

<DATE>

<PM NAME>
<PM ADD1>
<PM ADD2>
<PM CITY>, <PM STATE> <PM ZIP>

Dear Provider:

Thank you for responding to the referral authorization dated <INITIAL DATE>. You indicated in your response to this audit that the service for **<MEMBER NAME>**, **<MEMBER ID>**, was not authorized for date of service **<DOS>**.

We have been in contact with **<TRT PROV>** and received the enclosed documentation for the referral in question. We will consider the audit closed/resolved unless we receive further correspondence from you.

We appreciate your participation in the MediPASS program and your response to this audit. Many MediPASS patient managers have verbalized their concerns regarding the appropriate use of their authorization numbers. This verification is important to the integrity of the MediPASS program and the authority of the patient manager. Please feel free to contact us with any particular concerns you may have regarding the enclosed documentation or regarding the use of your authorization number.

Thank you again for your participation in the MediPASS program. We look forward to working with you in the future. If you have questions regarding this correspondence you may call 1-800-383-1173, extension _____, or (515) 974-XXXX

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

enclosure

MediPASS Referral Education Letter

<DATE>

<TREATING PROVIDER>
ADDRESS
City, State ZIP

Dear Provider:

This letter is being sent as follow-up to our letter dated <DATE>, requesting documentation of a MediPASS referral. You responded to that letter indicating that no supportive documentation of a MediPASS authorization could be produced.

A referral is needed from the designated MediPASS patient manager for ALL covered services, with the exception of emergency situations. Services provided during a medical emergency are exempt from authorization, although the provider of the service is asked to contact the patient manager in a timely fashion to let them know what services were provided. Additionally, follow-up treatment must be performed or referred by the patient manager.

The categories of service that MUST either be provided or authorized by the patient manager in order to be payable by Medicaid are identified on the enclosed page. Services that do NOT require patient manager referrals are also listed on each MediPASS member identification card.

If a member is seen by a provider or emergency room without authorization from the patient manager, the service is not payable unless it is a service excluded from patient manager authorization. All providers are encouraged to review identification cards each time a MediPASS member presents for care. This review will verify eligibility, MediPASS enrollment, the correct patient manager, and will also outline services requiring prior authorization from the patient manager.

Providers may contact the patient manager on behalf of a member to obtain authorization for a service. If the authorization is granted, covered services may be reimbursed by Medicaid. If the authorization is refused, no reimbursement is made by Medicaid.

Patient managers agree to provide care to all enrolled members by providing the necessary and appropriate health care, or by referring the member to other providers of medical care, as medically necessary and appropriate. Referrals should occur in accordance with accepted medical practice in the medical community.

If a MediPASS member persists in requesting service from a provider other than the designated patient manager, the provider from whom service is requested is responsible for informing the member that they are in a private pay status. Members may NOT be billed for unauthorized Medicaid covered services unless they are informed PRIOR to receiving the service that they will be responsible for the bill.

An authorization from the designated patient manager indicates approval for another provider to receive payment for services and does not speak to the quality or appropriateness of the care delivered. The authorization may be made for a single visit or an extended period of time, such as duration of illness or a specific number of visits. If the patient manager does not specify a continuation of services, a new referral must be obtained prior to treating a member for subsequent visits.

All authorizations of referrals for covered services should be noted in the members' medical record, especially in cases where the designated patient manager did not personally refer the member for care. The date, time, and person authorizing the referral should be included in this documentation. This documentation should be noted in the members' medical record in both the patient manager and treating provider offices.

The first incident regarding a disputed authorization of a paid claim results in the treating provider receiving this educational letter. If a pattern of disputed claims is identified, or it is found that unauthorized practices involving the improper use of the patient manager referral process has occurred, action will be taken by the Iowa Department of Human Services to recover unauthorized reimbursement(s).

We hope this information is helpful to you for future use of the patient manager referral process. If you have questions regarding this correspondence you can contact the Iowa Medicaid Enterprise Quality of Care department at 1-800-383-1173, extension _____, or (515) 974-XXXX

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

enclosure

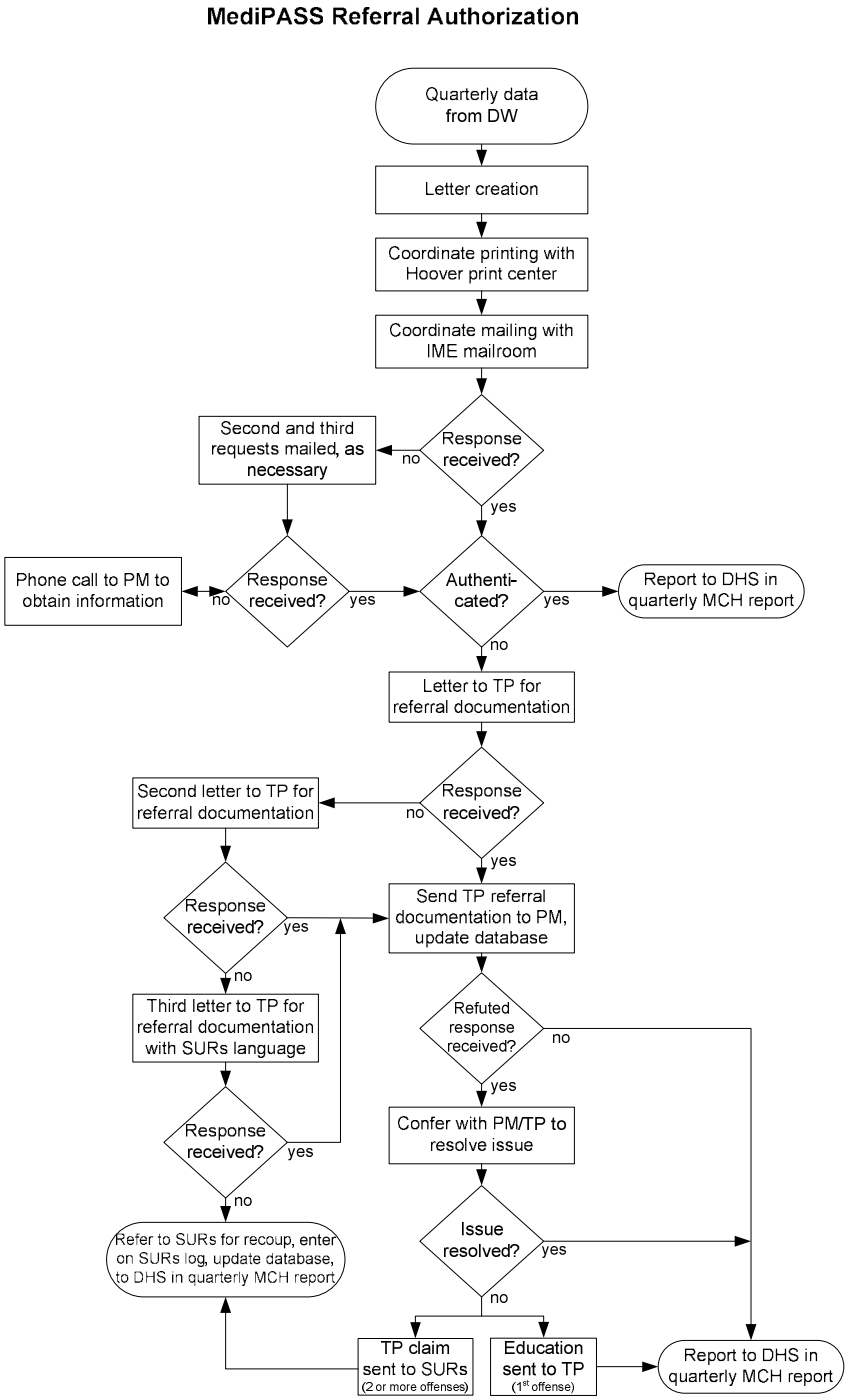
RFP Reference:

6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:



MED - Quality of Care MediPASS Encounter Data Validation

Purpose: Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter based data from MediPASS providers.

Identification of Roles:

Project Assistant – reviews random sample of MediPASS providers to ensure accurate sampling, requests claims from MMIS, requests medical records from patient managers, determines appropriate claim adjudication of claims through medical record review, and reports findings to DHS policy staff.

Senior Director – provides oversight to quality of care functions and makes recommendations to DHS policy staff regarding managed care programs.

Medicaid Medical Director (MMD) – Provides medical consultation when necessary.

Performance Standard:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The project assistant will receive a quarterly random sample of MediPASS claims from DW (25 inpatient claims and 25 outpatient claims).
Step 2: The project assistant will request medical records for claims selected in sample.
Step 3: The project assistant will review received medical records to determine if claims were appropriately paid.
Step 4: The project assistant will prepare a report detailing the results of the evaluation.
Step 5: The project assistant will forward quality of care concerns identified during the review to the MMD.
Step 6: The MMD will communicate concerns in writing to DHS policy staff.

Forms/Reports:

Medical Records Request Letter

DATE.....Prov ID: «ProvID»

«ProvName»
«Addr1»
«Addr2»
«City», «State» «Zip»

Dear Provider:

Iowa Medicaid Enterprise's (IME) Medical Services unit oversees the quality of care function for IME. The quality of care function is designed to monitor the care provided to Iowa Medicaid members. Medical Services focuses on the two managed care programs as the basis for this quality function. In order to validate encounter data for MediPASS, Medical Services is conducting an analysis to ensure adequate system entry and integrity of all the data.

A random sample of Iowa MediPASS members was selected. Encounter data reflects that services (Type is IP = inpatient, or OT = other) were provided by you for the member and dates listed below:

Type	Member ID	Member Name	**Dates of Service**
«Type»	«MbrID»	«MbrFN» «MbrLN»	«DOS1» - «DOS2»

Diagnosis from Claim: «DxCd»-«DxName»

Procedure from Claim: «ProcCd»-«ProcName»

Please copy all medical record documentation which authenticates the services received by the identified member for the identified service, and supply those records within 10 days to:

Iowa Medicaid Enterprise
Medical Services - Quality of Care FAX: (515) 725-1355
Attention: _____
PO Box 36478
Des Moines, IA 50315

Your assistance in completing this validation of encounter data is appreciated. **Complete medical records are not necessary, you need only supply documentation to support the specific procedure in question. For inpatient claims, please copy only the doctor order and results for the procedure in question.** If you have questions regarding this request you can contact me at (515) 974-XXXX or toll-free 1-800-383-1173, extension _____.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise, Medical Services

RFP Reference:

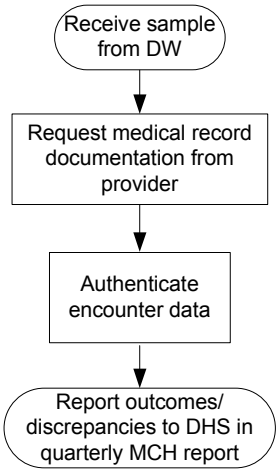
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

MediPASS Encounter Data Validation



MED - Quality of Care MediPASS Special Authorization and Good Cause Review

Purpose: Ensuring the MediPASS members have appropriate access to providers other than their assigned Program Manager if conditions exist for the deviation.

Identification of Roles:

Project Assistant – will receive telephonic referrals from treating providers, Member Services, or Provider Services staff.

Medicaid Medical Director (MMD) – Provides medical consultation when necessary.

Performance Standard:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The project assistant will receive telephone calls, workview notices, emails, or faxes from treating providers, Member Services, or Provider Services, as applicable.
Step 2: The project assistant will consider request for special authorization and approve as appropriate utilizing the following criteria:

a. If member has already requested a change in their patient manager
b. Services are for obstetrical and gynecological services
c. Patient manager refuses to treat or refer the member
d. Unique scenarios are sent for physician or policy review to determine if a special authorization can be given

Step 3: The project assistant will route any special authorization request that indicates a potential quality of care concern to the MMD for further review.
Step 4: The project assistant will log and monitor all requests for special authorization for patterns or trends according to provider or member.
Step 5: The project assistant will complete an informational letter to both patient manager and treating provider explaining the special authorization.

Forms/Reports:

Special Authorization Log Quarter Ending DATE

MbrLName	MbrFName	Mbr ID	Current PM Name	PMID	Date	Initiator	Reason
							B
							C
							X
							C
							A

Reason Codes: A - Administrative; B - PM unavailability; C - Continuity of Care; X - SA not given

Letter to Existing Patient Manager

DATE

CURRENT PM
ADDR1
ADDR2
CITY, ST ZIP

ProvID: #
NPI: #

RE: NAME ID: ID
DOB: ##/##/####

Dear Provider:

The member named above has been given an administrative authorization from the Iowa Medicaid Enterprise Medical Services department to receive services from **newPM**. This authorization is effective **date**, and is valid until the new card reflects the new patient manager choice (**date**).

Authorization of medical services is normally given at the discretion of the MediPASS patient manager. The Iowa Department of Human Services believes the MediPASS patient manager is the person most qualified to make medical decisions on behalf of their MediPASS members. Typically, an administrative authorization is not given to providers who have failed to contact MediPASS patient managers for a referral.

However, special circumstances occasionally occur where an authorization cannot be obtained and must be given by Medical Services staff. Medical Services staff has given an authorization to maintain the member's continuity of care.

If you have any questions regarding this authorization, you can contact me at 1-800-383-1173 or (515) 974-XXXX, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services - Quality of Care

Letter to New Patient Manager and/or Treating Provider

DATE

NEW PM/TP
ADDR1
ADDR2
CITY, ST ZIP

ProvID: #
NPI: #

RE: NAME ID: ID
DOB: ##/##/####

Dear Provider:

The member named above has been given an administrative authorization from the Iowa Medicaid Enterprise Medical Services department to receive services from your office. This authorization is effective **date**, and is valid until the new card reflects the new patient manager choice (**date**). The referral authorization that must be included on claims for this member is **ID/NPI.**

Authorization of medical services is normally given at the discretion of the MediPASS patient manager. The Iowa Department of Human Services believes the MediPASS patient manager is the person most qualified to make medical decisions on behalf of their MediPASS members. Typically, an administrative authorization is not given to providers who have failed to contact MediPASS patient managers for a referral.

However, special circumstances occasionally occur where an authorization cannot be obtained and must be given by Medical Services staff. Medical Services staff has given an authorization to your office to maintain continuity of care.

If you have any questions regarding this authorization, you can contact me at 1-800-383-1173 or (515) 974-XXXX, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Sincerely,

_____, Project Assistant
Iowa Medicaid Enterprise
Medical Services, Quality of Care

RFP Reference:

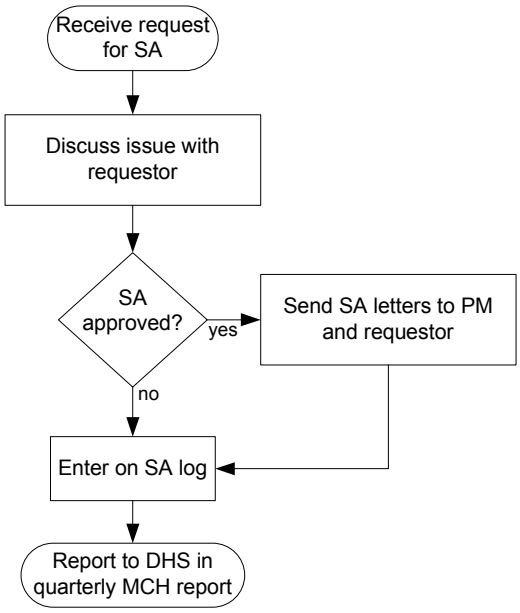
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:

N/A

Attachment A:

MediPASS Special Authorizations



MED - Quality of Care Internal Quality Control Process

Purpose: To provide continuous quality improvement to the Quality of Care functions and meet all performance standards.

Internal Quality Control (IQC) is a peer-to-peer review process completed monthly on randomly selected completed reviews from the previous month or quarter.

Identification of Roles:

Manager – performs IQC on selected reviews and reviews results of IQC reviews with follow-up on any quality concerns.

Project Assistant – works with manager to resolve discrepancies following IQC reviews

Path of Business Procedure:

Step 1: Manager will randomly select the number of reviews per type of review identified below:

a. 45 Quarterly referral authorization responses per quarter
b. 5 24-hour survey calls per quarter
c. 15 Special Authorizations per month
d. 5 Iowa Plan chart audits per quarter

Step 2: Quarterly Referral Authorizations

a. Manager will randomly select 45 quarterly referral authorizations reviews per quarter.
b. Manager will refer to the Quarterly Referral Authorization logging database to find the DCNs of the documents in OnBase.
c. Manager will find the appropriate document in OnBase and compare the responses on the letter to the information entered in the database and ensure the appropriate follow-up and/or resolution letters were sent.
d. Any discrepancies will be discussed with the project assistant and resolved.

Step 3: 24 Hour survey calls.

a. Manager will randomly select 5 of the 24-Hour survey calls completed each quarter.
b. Manager will recall the phone numbers and ensure the results of the review are validated and that the appropriate follow-up was completed.
c. Any discrepancies will be discussed with the project assistant and resolved.

Step 4: Special Authorizations

a. Manager will randomly select 15 special authorizations per month.
b. Manager will refer to the Special Authorization log to ensure special authorizations were approved or denied according to the DHS identified criteria.
c. Any discrepancies will be discussed with the project assistant and resolved.

Step 5: Iowa Plan Chart Audits

a. Manager will randomly select 5 Iowa Plan chart audits per quarter.

b. Manager will refer to the Iowa Plan logging database to find the DCN of the documentation for review.
c. Manager will find the appropriate documentation in OnBase and review ensuring the documentation supports the services billed.
d. Any discrepancies will be discussed with the project assistant and resolved.

Step 6: All IQC results are tracked by the Manager in the Team IQC tracking log.

Forms/Reports:
N/A

RFP Reference:
6.2.3
6.2.8
6.2.8.1
6.2.8.2

Interfaces:
N/A

Attachments:
N/A