

EQR PROTOCOL 1 – ASSESSING MCO COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS

Attachment D: Compliance Interview Questions

The purpose of this Attachment to Protocol 1 is to provide the reviewer(s) with sample review questions that should be answered to the fullest extent possible during initial document review and subsequent site visit document review. Questions left unanswered in the judgment of the reviewer after document reviews have been completed should be incorporated into the site visit interviews.

The review questions are organized according to the MCO staff groups who are likely the most appropriate individuals to answer the questions. Reviewers are encouraged to interview MCO staff in appropriate groups whenever possible in order to accomplish a comprehensive review from more than one perspective, and to achieve efficient and productive interviews.

The MCO interviewee groups who are most often interviewed are included in this guide:

- [MCO leaders](#)
- [HMO information systems staff](#)
- [Quality Assessment and Performance Improvement Program staff](#)
- [Provider/ Contractor services staff](#)
- [Enrollee services staff](#)
- [Utilization management staff](#)
- [Medical directors](#)
- [Case managers and care coordinators](#)
- [MCO providers and contractors \(as appropriate\)](#)

The interview(s) may include discussion about specific policies or documents. Suggested interview questions are provided in this Attachment to Protocol 1, but should be flexible enough to generate open conversation as appropriate for the information the reviewer is seeking. The EQRO will identify specific issues for which the MCO will be interviewed during the site visit. The MCO representative for the EQR process will select and report to the EQRO in writing the membership of each of the interviewee groups which are capable of responding to the EQRO site visit interview topic requests. Suggested interviewee groups are listed below.

MCO Leaders

The leadership interview is an opportunity to talk with the senior representatives of the MCO about their understanding and practice of the following MCO requirements. In attendance, the following MCO leaders should be present during the interview(s), with discretion from the EQRO as needed on the availability of documented information (or other appropriate staff) when recommended attendee participation is burdensome or difficult to schedule:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0786. The time required to complete this information collection is estimated to average 1,591 hours per response for all activities, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

- Chief executive officer (CEO);
- Chief operating officer (COO), when applicable;
- Chairman of the governing body, or a representative, when applicable;
- Medical director (including psychiatric medical director, if applicable);
- Chief elected or appointed officer of the MCO 's licensed independent practitioners (where found);
- Chief information officer (CIO), when applicable;
- Compliance officer;
- Quality improvement committee chairperson;
- Quality improvement program director or coordinator; and
- Human resources leader.

As determined by the MCO representative, usually in consultation with the CEO, other senior staff of the MCO may also be in attendance. However, attendance at this interview should be carefully limited in order to foster candor and the free exchange of information.

Enrollee Right to Information (438.100)

1. How does your MCO give each enrollee written notice of any change (that the State defines as “significant”) in the information specified above, at least 30 days before the intended effective date of the change? How does the State define “significant”? Have you made any such “significant” changes in the last year?
2. Have you terminated the contract of any providers in the last year? If so, did you provide written notice to each of the provider’s patients within 15 days of the termination?
3. How do you ensure that your staff and affiliated providers comply with Federal and State laws that pertain to enrollee rights?
4. What information does your MCO disseminate to Medicaid enrollees? How does your MCO make this information available, and how often?

Enrollee Right to Respect, Dignity, Privacy (438.100)

1. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights such as treatment with respect, dignity, and consideration for privacy and confidentiality of information? Provide examples.
2. What processes are in place to ensure that staff members observe the MCO’s policies and procedures on privacy and confidentiality of enrollee information?
3. What does the MCO do to raise staff awareness of its policies on nondiscriminatory behavior towards enrollees? How is staff monitored to determine that they comply with these policies?

Enrollee Right to Receive Information on Available Treatment Options (438.100 and 438.102)

1. How does the MCO ensure that providers share information on available treatment options and alternatives with enrollees? Does this include alternatives and options that are outside, as well as within, the Medicaid contract’s scope of benefits?

2. What steps does the MCO take to ensure that enrollees receive information on available treatment options and alternatives in a manner appropriate to their condition and ability to understand?

Enrollee Right to Participate in Decisions Regarding His/Her Health Care and Advance Directives- (438.100 and 438.6)

1. How does the MCO facilitate enrollee participation in care and treatment decisions? Describe.
2. Does the MCO have any limitations in implementing State and Federal laws pertaining to advance directives? If so, what are these?

Compliance with other Federal and State laws (438.100)

1. What steps do MCO leaders take to ensure compliance with Federal and State laws on enrollee rights?
2. Has the MCO ever been found non-compliant with any Federal and State laws on enrollee rights? If yes, in what area, and what steps were taken to clear the violation?
3. If a provider/contractor is found to be in violation of any Federal and State laws on enrollee rights, how does the MCO respond?
4. To what extent does the MCO orient new staff to Federal and State laws on enrollee rights that must be observed during day-to-day operations? How does the MCO remind staff of the importance of observing these laws during interactions with other employees and with enrollees?
5. Describe the steps taken by the MCO when staff report, or are involved in a violation of Federal or State laws on enrollee rights.

Availability of Services (438.206)

1. Describe the MCO's process for assessing the needs for providers to deliver each type of covered service and need for major specialties within each type. What issues were considered in the assessment process?
2. How does the MCO determine the adequacy of its network to serve its Medicaid enrollees?
3. What assumptions and methodologies are used to project the number, type (in terms of training, experience, and specialization) and location of primary care providers and specialists necessary to serve its anticipated Medicaid enrollees?

Out-of-Network Providers (438.206(b)(3) through (5))

1. Approximately what proportion of Medicaid enrollee provider encounters are made to out-of-network providers? If this is a significant percent, what are the reasons for this?

2. How do you pay out-of-network providers? Do you receive claim, encounter data from out-of-network providers similar to the claim, or encounter data that you receive from your network providers?
3. How does your MCO ensure that any costs to the Medicaid enrollee for out-of-network services is no greater than the costs the Medicaid enrollee would incur if they used a network provider for the same service?

Furnishing of Services and Timely Access (438.206(c)(1))

1. Describe how the MCO monitors for compliance with its Medicaid standards for timely access to care and services.
2. How does the MCO ensure the 24 hours per day, 7 day per week availability of Medicaid services included in its contract with the State when medically necessary?
3. How does the MCO determine that the individual and institutional providers it contracts with have sufficient capacity to make services available when medically appropriate 24 hour per day, 7 days per week to Medicaid enrollees?
4. How does the MCO ensure that its provider network's hours of operation do not discriminate against Medicaid enrollees (i.e., are not different for Medicaid enrollees than for commercial enrollees)?
5. How big of a problem is inappropriate use of emergency rooms by your Medicaid enrollees?
6. What was the volume of denied claims for emergency and post-stabilization services in the most recent year?

Cultural Considerations (438.206(c)(2))

1. What have been the State Medicaid agency's efforts to promote the delivery of services in a culturally appropriate manner to all enrollees, including those with diverse cultural and ethnic backgrounds? How has your MCO participated in these efforts? What documentation exists describing your efforts and the results of your efforts?
2. What have been the MCOs efforts to promote services to enrollees with limited English proficiency and those with low literacy?

Coordination and Continuity of Care (438.208)

1. How are "individuals with special health care needs" defined by the State Medicaid agency? Has your MCO developed any other operational definition or definitions of individuals with special health care needs? If yes, what is/are these and how were they developed? How do they differ from the State definition?
2. Does the State Medicaid agency require your MCO to screen Medicaid enrollees to identify those with special health care needs?
3. How are individuals with special health care needs - including both individuals with special health care needs identified by this MCO and those identified by the State Medicaid agency or its agent - identified and tracked within your MCO?

4. Does the State Medicaid agency require your MCO to assess Medicaid enrollees with special health care needs? If yes, how are these activities conducted?
5. Who may serve as enrollee primary care providers?
6. What steps does the MCO take to promote Medicaid enrollees' ongoing relationship with a usual source of primary care?
7. What processes are used to coordinate services for enrollees? Are there different types of care coordination mechanisms for different types of enrollees? If so, what are these?
8. If your MCO establishes separate coordination of care for medical services and mental health and substance abuse services, how does it ensure exchange of necessary information between care coordinators? How does it ensure information exchange among providers?
9. How does the MCO ensure coordination of its services with services enrollees may receive from other MCOs?
10. Under what circumstances may Medicaid enrollees have direct access to specialists?
11. How does your MCO manage the provision of any specialty care services currently not provided in-network?
12. Does your MCO require written treatment plans to be developed for enrollees? If yes, under what circumstances are written treatment plans required?

Coverage and Authorization of Services, Including Emergency and Post-Stabilization Services (438.210 and 438.114)

1. What percent of emergency department care utilized by your Medicaid enrollees is for non-urgent care?
2. Has your MCO investigated a potential relationship between inappropriate emergency room use and enrollee access to routine and urgent care?
3. What was the rate of denied claims for emergency and post-stabilization services in the most recent year?

Provider Selection and Non-Discrimination (438.214 and 438.12)

1. What is the basis or criteria used to determine individual provider participation in the MCO's network?
2. What is the basis or criteria used to determine institutional or other non-individual practitioner participation in the MCO's network?
3. What types of providers are subject to the MCO's credentialing process?
4. Describe the provider credentialing process used by the MCO.

5. What steps does the MCO take to ensure that it does not employ or contract with providers who have been excluded from participation in Federal health care programs?
6. What steps does the MCO take to ensure that providers who serve high-risk or costly populations are not discriminated against in the selection process, and when considering reimbursement and indemnification?
7. What criteria is the basis for denial of provider participation in the MCO's network?

Grievance systems (438.228)

1. How does your MCO track requests for covered services that your MCO or its providers has denied?
2. What was the volume of denied claims for services in the most recent year?
3. How do you ensure that Medicaid enrollees who were denied services were notified of their right to a State fair hearing?

Sub Contractual Relationships and Delegation (438.230)

1. What services and activities are delegated to and performed by sub contractors?
2. Describe the MCO's process for identifying and selecting contractors? How is it determined that a contractor has the ability to perform the activities that are to be delegated
3. Describe how your MCO assesses the quality of delegated services.

Practice Guidelines: Adoption (438.236(b))

1. What organizational component is responsible for the adoption of practice guidelines used by your MCO?
2. How does your MCO establish priorities for adoption of practice guidelines? How does your MCO consider the enrolled Medicaid population's health needs in the adoption of practice guidelines?
3. What guidelines has your MCO adopted?
4. By what process were they adopted?
5. To what extent are your MCO's guidelines "evidence-based"?
6. How does your MCO consider the enrolled Medicaid population's health needs in the adoption of practice guidelines?
7. How are affiliated providers consulted as guidelines are adopted and re-evaluated?
8. What mechanism(s) does your MCO have for periodically evaluating and updating the guidelines it has adopted?

Practice Guidelines: Dissemination and Application (438.236(c))

1. How are practice guidelines disseminated to providers?
2. When and how are guidelines disseminated to enrollees and potential enrollees?
3. To what extent are the practice guidelines adopted by your MCO a component of your MCO's Quality Assessment and Performance Improvement (QAPI) program?
4. Is there an interface between the QAPI program and practice guidelines adoption process?
5. What steps are taken to ensure that decision-making in the areas of utilization management or coverage determinations and other functional areas are consistent with the adopted practice guidelines?

Quality Assessment and Performance Improvement Program (438.240)

1. How does your MCO define enrollees with "special health care needs"? How are these enrollees identified/ tracked within your MCO?
2. How does your MCO assess the quality and appropriateness of care furnished to enrollees with special health care needs?

Quality Assessment and Performance Improvement Program: Program Review by the State (438.240(e))

1. Does the MCO evaluate the effectiveness of its quality assessment and performance improvement program? How often?
2. What were the findings of the MCO's most recent self-evaluation of its QAPI? What action did the MCO take as a result of these findings?

Health Information Systems (438.242)

1. Describe the types of data collection systems that are in place to support the clinical and administrative operations of your MCO. Specifically, what data is routinely collected to support utilization management, grievance systems, and enrollment services?
2. What processes are in place to obtain data from all components of your network (e.g., health care facilities, physician, and laboratories)? To what extent does your MCO require and receive data in standardized formats? Are there any components of your network from which you do not receive standardized (or any) information on services?
3. How are enrollee and provider data collected and integrated across all components of your MCO's network? How is this used to produce comprehensive information on enrollee needs and utilization and to otherwise support management?

Grievance System: General Requirements (438.402)

1. Who in the MCO is responsible for the development and oversight of the appeals and grievance resolution process and access to State fair hearings?

2. What have been the volume of appeals/grievances/requests for State fair hearings in the past year and the most common areas of concern expressed by Medicaid enrollees? How has the MCO addressed these concerns?
3. Describe the notice and appeals process for adverse actions on enrollee requests for services or payment. Elaborate on the particular steps, including time frames.

Handling of Grievances and Appeals (438.406)

1. To what extent does your MCO provide Medicaid enrollees with assistance in completing forms and taking other procedural steps in the grievance and appeal process? How does it do this?
2. How does your MCO treat oral requests by Medicaid enrollees to appeal actions?
3. As part of an appeal, to what extent do enrollees and their representatives have an opportunity to:
 - i. Present evidence, and
 - ii. Examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
4. What are the qualifications and credentials of individuals who make decisions on grievances and appeals? How does the MCO ensure that these individuals:
 - i. Were not involved in any previous level of review or decision-making; and
 - ii. If deciding any of the following, have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - a. An appeal of a denial that is based on lack of medical necessity;
 - b. A grievance regarding denial of expedited resolution of an appeal;
 - c. A grievance or appeal that involves clinical issues?
5. Is there a process in place to monitor either the appeal and grievance process or the areas of concern identified by enrollee appeals and grievances?

Resolution and Notification: Grievances and Appeals (438.408)

1. Approximately how many grievances did the MCO receive in the most recent reporting year?
2. Approximately how many appeals did the MCO receive in the most recent reporting year?
3. Approximately what percent of notices of action on requests for service authorization or payment by Medicaid enrollees are appealed to the MCO?
4. Approximately what percent of notices of action on requests for service authorization or payment by Medicaid enrollees are appealed to the State fair hearing process? Approximately what percent of these are overturned by the State?

Expedited resolution of Appeals (438.410)

1. Is there a process in place for those instances when an enrollee's health condition requires expedited resolution of an appeal? Describe this process. What are the time frames for this process?

2. Are physicians allowed to request expedited appeals on behalf of an enrollee? How does the MCO protect physicians who make such requests?

Information about the Grievance System to Providers and Subcontractors (438.414)

1. Who in your MCO has responsibility for the proper functioning of the grievance process and the authority to require corrective action?
2. Did your State Medicaid agency develop or approve the description of your MCO's grievance system provided to Medicaid providers? Which, develop or approve? If it approved your description, how is the State's approval documented?

Recordkeeping and reporting requirements: Grievances and appeals (438.416)

1. Where in your MCO are records on Medicaid enrollee grievances and appeals kept?

MCO Information Systems Staff

This interview will assess the MCO's information management function and how it relates to and supports the other functions of the organization, such as planning and operations, quality assessment and improvement program activities, care coordination, etc. This is also an opportunity to explore the extent to which the health information needs of the entire MCO and provider network are measured, assessed, and, as indicated, improved.

The interview should include MCO staff responsible for health information systems issues at the MCO. It should not be limited to just those responsible for technology implementation, but should also include staff that are responsible for the quality of information, movement of information, sharing of information, and information policy and procedure development and implementation.

Information System Capabilities

The interviewees should receive a copy of the MCO's Information Systems Capability Assessment (ISCA) (see Appendix V) that either has been completed in the last two years by an independent organization reviewing the MCO or has been completed by the organization conducting this compliance review. The findings of the ISCA will serve as a guide to conducting this interview. During this interview, validate the information provided about the MCO on the ISCA, explore any areas of concern, and gather missing or additional information for use in evaluating standards compliance, paying particular attention to how data are defined and captured across the MCO and how data transmission and integration takes place across the MCO. Questions and areas of discussion should be based on the findings of the ISCA, and may include:

1. What are the findings of the most recent assessment of the MCO's information systems capacity? Are the findings reflective of your own assessment of capabilities?
2. What are your information system's strengths and weaknesses? What has the MCO done to address information system problem areas?
3. What information needs does your MCO have that are not currently met by your present information system? What has the MCO done to address these needs?
4. Is the data collected from network providers on services to enrollees subject to accuracy and timeliness checks?
5. Describe procedures used to screen all data, both internal and external, for completeness, logic, and consistency.
6. How is enrollee-specific data and information made available when and where needed by the MCO's provider network?

Delivery Network (438.206)

1. How does your information system track services provided by and/or reimbursed to out-of-network providers?
2. Describe the capabilities to routinely collect data on use of out-of-network providers (excluding Point of Service-related use). Is data on use of out-of-network providers separately available for Medicaid enrollees?

Health Information Systems (438.242)

1. How is the data collected from network providers on services to enrollees checked for accuracy and timeliness?
2. Describe procedures used to screen all data, both internal and external, for completeness, logic, and consistency.

Quality Assessment and Performance Improvement Program Staff

This interview with quality improvement program leaders and staff provides an opportunity to gain a more thorough understanding of the approaches and processes used by the MCO to assess and improve quality.

Furnishing of services-timely access (438.206(c))

1. Describe any recent QAPI activities implemented to monitor the MCO's compliance with its established standards for timeliness of access to care and member services.
2. What are the results of these QAPI activities?

Provider selection (438.214)

1. What type of information is generated through the quality improvement program to support re-credentialing of individual practitioner providers?
2. What types of information does the quality improvement program provide to support the re-credentialing of institutional and other non-practitioner providers?

Practice guidelines (438.236)

1. How does the QAPI program interface with the administrative function responsible for adopting practice guidelines?

Quality assessment and performance improvement program (438.240)

1. Does the State require your MCO to address a specific topic or topics and/or indicators in your performance improvement projects? If yes, what types of projects are required?
2. How does your MCO detect over- and under-utilization? Provide examples of how your quality assessment and improvement program has monitored to detect under- and over-utilization. What standards are used?
3. How does your MCO define enrollees with "special health care needs"? How are these enrollees identified/ tracked within your MCO?
4. How does your MCO assess the quality and appropriateness of care furnished to enrollees with special health care needs? Provide examples.

5. Does the MCO evaluate the effectiveness of its quality assessment and performance improvement program? How often?
6. Describe the evaluation process. What aspects of the program are encompassed in the evaluation?
7. What were the findings of the MCO's most recent self-evaluation? What action did the MCO take as a result of these findings?
8. Is the evaluation conducted to meet the State's requirements, and if so, what is reported to the State and how often?

Health information systems (438.242)

1. How are enrollee and provider data from all components of your MCO's network used in your MCO's quality assessment and performance improvement program? Are there any components in your network for which you do not have adequate enrollee utilization and provider data?
2. How is data obtained from the meaningful use of certified electronic health records (EHRs) utilized as part of the MCO's quality improvement program?

Handling of grievances and appeals (438.406)

1. What is the process used to monitor the appeal and grievance process?
2. What is the process to monitor areas of concern identified by enrollee appeals and grievances?

Recordkeeping and reporting requirements on grievances and appeals (438.416)

1. To what extent is information on Medicaid enrollee grievances and appeals analyzed and included as part of your MCO's Quality Assessment and Performance Improvement Program?

Provider/Contractor Services Staff Interview

This is an interview of MCO staff members who are responsible for establishing and maintaining communications with the MCO's individual practitioners and other types of health care providers (e.g., organizations). This includes staff responsible for management of the credentialing process and oversight of delegated activities. Through these interviews, the reviewer(s) will assess enrollee rights; the credentialing and appointment process, oversight of the providers; and how information is communicated to providers.

Enrollee rights (438.100)

1. How does the MCO inform its individual and institutional providers about enrollee rights and responsibilities? How does the MCO monitor for compliance with these rights by its providers?

2. To what extent, if any, does the MCO supply providers with information on where to refer enrollees who are having difficulty understanding the materials that have been provided to them by the MCO?
3. Does the MCO require providers to have access to oral interpreter services? Does the MCO supply providers with guidance or assistance in accessing oral interpreter services if necessary?
4. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights to treatment with respect, dignity, and consideration for privacy? Provide examples.
5. How does the MCO ensure that enrollees are not discriminated against in its own facilities and those of its affiliated providers when seeking health care services consistent with their covered benefits?
6. Describe the MCO's credentialing and oversight process for primary care providers, other health care professionals and institutional providers. What is encompassed by reviews and evaluations of these providers? Do these processes involve visits to the providers' care delivery sites?
7. What methods are used to encourage providers to share information on available treatment options and alternatives with enrollees?
8. What processes are in place for monitoring providers to determine that they are providing information on available treatment options and alternatives?
9. What requirements does the MCO have for providers/contractors relative to enrollee advance directives? How is it determined that providers/contractors are meeting the MCO's requirements?
10. How does the MCO inform its individual and institutional providers about enrollee rights to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional? How does the MCO monitor for compliance with these rights by its providers?
11. How are the MCO's network providers informed of enrollees' right to request and receive a copy of their medical records, and to request that they be amended or corrected?
12. What steps does the MCO take to ensure that providers/contractors are aware of and in compliance with applicable Federal and State laws on enrollee rights?
13. If a provider/contractor is found in violation of any Federal and State laws on enrollee rights, what action is taken by the MCO ?

Availability of services (438.206)

1. Describe the MCO credentialing and re-credentialing process. Is this different for Medicaid providers?
2. How is it determined that providers are geographically accessible to Medicaid enrollees and physically accessible to enrollees with disabilities?

3. Describe the processes for monitoring the provider network to determine that Medicaid requirements pertaining to timeliness, availability and accessibility are being met. What are the most recent findings from this process?
4. How often in the last year has your MCO had to arrange for services or reimbursements to out-of-network providers?

Timely access to service (438.206(c))

1. Are MCO/ PIHP and provider services available 24 hours a day, 7 days a week, when medically necessary?
2. Are the hours of operation of the provider network serving Medicaid enrollees different from the hours of operation of the provider network serving other enrollees? If yes, why are they different?
3. Does the MCO continuously monitor its provider network for compliance with established standards on timeliness of access to all care and member services? If yes, how, and what are the most recent findings?
4. What steps are taken to address provider non-compliance with established standards for timeliness of access to care and member services? How are corrective actions assessed for effectiveness? Describe the follow up and monitoring.

Coordination and continuity of care (438.208)

1. How are primary care providers serving enrollees with special health care needs made aware of and involved in procedures for:
 - assessing individuals with special health care needs?
 - ensuring that treatment plans address the needs identified by the assessment?
 - assuring appropriate use of specialists?
 - coordinating primary care services with care provided by other MCOs and PIHPs serving the enrollee?
2. How are specialty providers serving enrollees with special health care needs made aware of and involved in procedures for:
 - assessing individuals with special health care needs?
 - ensuring that treatment plans address the needs identified by the assessment?
 - coordinating specialty care services with care provided by other MCOs and PIHPs serving the enrollee?

Coverage and authorization of services (438.210)

1. Do contracts/agreements with individuals or organizations performing utilization review provide for any performance incentives? If yes, please describe the incentives. [Note to reviewers: Look for any incentives for denying, limiting, or discontinuing authorization of services.]
2. Are network providers notified of the information ordinarily required to process an authorization request?

3. Describe the process for notifying the requesting provider of any decision to deny, limit, or discontinue authorization of services. What are the MCO's time frames for notification?

Provider selection (438.214)

1. What types of individual practitioners are subject to the MCO's credentialing process?
2. Describe the MCO's credentialing processes for individual practitioners. How often does this process take place? What items of credentials information are updated during the process? Are site visits made to providers? When and how often? How is it determined that a site visit will be made? Who is involved in the MCO's credentialing activities?
3. Describe the MCO's recredentialing processes for individual practitioners. What types of information are monitored and reviewed during the recredentialing process? What other operations of the MCO contribute information to be used in the recredentialing process?
4. Describe the MCO's /PIHP's processes for selecting and monitoring institutional and other non-practitioner network providers. What information is reviewed as a part of this process? Are site visits made? When and how often?
5. Describe the MCO's credentialing and recredentialing processes for institutional providers. How frequently is re-credentialing performed? What items of information are typically reviewed during the evaluation and reevaluation process?
6. Are site visits a part of the process to credential and re-credential institutional providers?
7. What other MCO operations contribute to the evaluation of a network institutional provider?
8. What criteria is the basis for denial of provider participation in the MCO's network?

Grievance systems (438.228)

1. Describe the process for notifying the requesting provider of any decision to deny, limit, or discontinue authorization of services. What are the MCO's time frames for notification?

Sub contractual relationships and delegation (438.230)

1. What types of activities are performed by (and thereby delegated to) contractors?
2. Describe your MCO's process for identifying and selecting contractors? How is it determined that a contractor has the ability to perform the activities that are being delegated by the organization?
3. What steps does your MCO take to determine that an entity to which functions will be delegated is capable of performing the function? Describe any evaluation process that your MCO has in place.
4. For each of the activities that have been delegated:
 - Is there any ongoing monitoring and review of entities performing delegated activities? How this is accomplished? Is the process the same for all delegates at all times? Are

there any instances when your MCO varies the monitoring process or the timing of evaluation?

- Does your MCO perform an annual evaluation of the delegate's performance? Describe the process undertaken to conduct this evaluation. What is included in the evaluation?
- What is done with the results of delegate evaluations? Do the results of the most recent delegate evaluations specify any necessary corrective action for problems or deficiencies identified? Describe some of the recommendations made to delegates in an effort to improve performance.
- What steps does your MCO take to assure that the delegate implements corrective actions?
- Who in the MCO is assigned responsibility for monitoring the delegate's performance?

Practice guidelines (438.236)

1. What mechanism is in place to consult affiliated providers as practice guidelines are adopted and re-evaluated?
2. How are practice guidelines disseminated to providers?

Health information systems (438.242)

1. Does the MCO have data collection requirements for health care facilities and physicians? How are the requirements relayed to these organizations and individuals?
2. If issues arise in the timeliness and accuracy of the data that is being collected and submitted, who notifies the health care facility or physician?

Information about the grievance system to providers and subcontractors (438.414)

1. When are providers given information about the MCO's Medicaid complaint and grievance system? What is typically included in the information given to providers relative to Medicaid grievances?

Enrollee Services Staff Interview

The enrollee services staff interview provides an opportunity to speak with MCO staff members who are responsible for communicating with enrollees. This includes those individuals responsible for written communication, phone responses to inquiries and problems, the complaint and grievance system and other services designed to assist Medicaid enrollees in their use of MCO services. Through this interview, the reviewer(s) will assess the manner in which the MCO and its provider network address issues relating to the rights of enrollees; the MCO's efforts regarding enrollee education and communication; the mechanisms in place to insure that information needed to provide services to enrollees is available throughout the MCO; and the aspects of enrollee services are measured, how collected data is assessed, and what efforts have been made to improve enrollee services.

Enrollee right to information (438.100 and 438.10)

1. What information is routinely provided to Medicaid enrollees? What is the process for disseminating information to new and existing enrollees? How often is information distributed to existing enrollees? In what format is this information presented?
2. Describe or provide copies of the formats in which information is presented to enrollees.
3. In what languages or alternative formats are enrollee materials and information presented? How was it determined that materials were needed in different languages?
4. Does the MCO provide written materials in alternative formats for the visually impaired? How did the MCO determine this?
5. Describe the procedure for handling calls to the MCO from non-English speaking enrollees. What instruction or guidance is available for providers that may need interpretation assistance to provide care and services to assigned enrollees?
6. To what extent is the MCO responsible for responding to requests for information for potential Medicaid enrollees?
7. How does the MCO inform enrollees (and potential enrollees, if applicable) about how to obtain oral interpreter services if they have limited proficiency in English?
9. Are there any benefits that an enrollee is entitled to under the Medicaid program, but that are not made available through the MCO contract? What are those benefits? How are enrollees made aware of the Medicaid program benefits that are outside the scope of services available through the MCO?
10. How does the MCO ascertain the primary language spoken by the individual Medicaid enrollees?
11. Are enrollees provided with a listing of primary care providers? Does the listing include Providers' non-English language capabilities?
12. Does your MCO give written notice of termination of a contracted provider to enrollees who receive primary care from, or are seen on a regular basis by, the terminated providers? How is this accomplished? Have you had to make any such notifications in the last year?
13. Does your MCO give enrollees any notice of significant changes change in the information specified above? When and how does this occur? Have you had to make any such notifications in the last year?

Enrollee right to respect . . . dignity, and . . . privacy (438.100)

1. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights to treatment with respect, dignity, and consideration for privacy? Provide examples.

Enrollee right to participate in decisions regarding his or her health care (438.100) and regarding advance directives (438.10(g))

1. To what extent does the MCO allow enrollees to participate in care and treatment decisions? Describe some of the ways in which this is accomplished.

2. To what extent are Medicaid enrollees informed at the time of enrollment of their right to accept or refuse treatment and to execute an advance directive and the MCO's policies on implementation of that right?

Enrollee right to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional (438.100)

1. How does the MCO monitor for compliance with enrollee rights to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional? What are the most recent results of this monitoring?

Enrollee right to request and receive medical records (438.100)

1. How do enrollees obtain access to their medical records maintained by the MCO, including records maintained by providers/contractors from whom the enrollee has received services?
2. How are enrollees informed of their right to request and receive a copy of their medical records, and to request that they be amended or corrected?
3. Has the MCO received any complaints about an enrollee's inability to timely access their medical records? If yes, what was the volume and nature of the complaints? How were they resolved?

Compliance with other Federal and State laws (438.100)

1. Does the MCO orient staff to the federal and State laws on enrollee rights that must be observed during day-to-day operations? Does the MCO remind staff of the importance of observing these laws during interactions with other employees and with enrollees?
2. Describe the procedure for handling an enrollee complaint involving a perceived violation of their rights.

Availability of Services (438.206)

1. What processes does the MCO take to monitor availability and accessibility of services to Medicaid enrollees? What are the most recent findings from this process?
2. Is there any information that is routinely collected and monitored to determine that care and services are being rendered to Medicaid enrollees in a timely manner? What are the most recent findings of this monitoring?

Availability of services-Delivery network (438.206(b))

1. Are Medicaid enrollee requests for out-of-network providers tracked? How often do Medicaid enrollees request services from out-of-network providers? What are their reasons for requesting out-of-network providers?
2. How often do Medicaid enrollees receive services from out-of-network providers?

Availability of services-Furnishing of services (438.206(c))

1. Are MCO/ PIHP and provider services available 24 hours a day, 7 days a week, when medically appropriate?
2. How frequently does enrollee services staff receive complaints about provider hours of operations not being available to enrollees when medically necessary?
3. Does the MCO conduct surveys, focus groups or other activities to receive the feedback of Medicaid enrollees? If so, what are the most recent findings about Medicaid enrollee perceptions about availability of MCO and provider services?

Coordination and continuity of care (438.208)

1. How are Medicaid enrollees with special health care needs - including both any individuals with special health care needs identified by your MCO and any identified by the State Medicaid agency or its agent - identified and tracked within your MCO?
2. How does this MCO identify and assess Medicaid enrollees with special health care needs?
3. What proportion of Medicaid enrollees has an ongoing source of primary care?

Coverage and authorization of services (438.210)

1. How frequently does enrollee services staff receive complaints about difficulty obtaining emergency or post-stabilization services?
2. Describe the procedure for handling member calls regarding need for emergency services.

Enrollment and disenrollment (438.226)

1. Describe the procedures that are followed when a request for disenrollment is received from an enrollee.
2. How is disenrollment information tracked through or by other MCO operations (e.g., grievance process, quality improvement, administration)? How many requests by Medicaid enrollees were received last year for disenrollment? What were the cited causes?

Grievance systems (438.228)

1. Describe the process for notifying Medicaid enrollees of any decision to deny, limit, or discontinue a request for service. What are the MCO's time frames for notification?

Practice guidelines (438.236)

1. How often does your MCO receive requests from enrollees and potential enrollees for practice guidelines? How does your MCO respond to these requests?
2. When and how does your MCO disseminate practice guidelines to enrollees?

Grievance system - general requirements (438.402)

1. What enrollee materials contain information about the complaint and grievance processes? When are enrollees presented with this information?
2. Describe the process for handling authorization decisions that are adverse to the enrollee.

Handling of grievances and appeals (438.406)

1. What MCO department or staff members are responsible for assisting enrollees to use the organization's complaint or grievance system, including completing forms, or taking other steps to resolve an appeal or grievance? What kind of assistance is made available to Medicaid enrollees?
2. What are the qualifications and credentials of individuals who make decisions on grievances and appeals? How does the MCO ensure that these individuals:
 - were not involved in any previous level of review or decision-making; and
 - if deciding any of the following, have the appropriate clinical expertise in treating the enrollee's condition or disease.
 - (A) An appeal of a denial that is based on lack of medical necessity.
 - (B) A grievance regarding denial of expedited resolution of an appeal.
 - (C) A grievance or appeal that involves clinical issues?
3. How does your MCO treat oral requests by Medicaid enrollees to appeal actions?
4. As part of an appeal, to what extent do enrollees and their representatives have an opportunity to:
 - Present evidence and
 - examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

Resolution and notification: Grievances and appeals (438.408)

1. Describe the MCO's grievance resolution process.
2. Describe the MCO's appeal resolution process. Are Medicaid enrollees required to exhaust the MCO's internal appeals process before seeking and receiving a State fair hearing?
3. How is it determined that an enrollee's appeal requires expedited resolution?
4. What percent of appeal resolutions that are completely or partially adverse to Medicaid enrollees are appealed to the State fair hearing process? Of these, what percent are overturned by the State Medicaid agency?

Expedited resolution of appeals (438.410)

1. Is there a process in place for those instances when an enrollee's health condition requires expedited resolution of an appeal? Describe this process. What are the time frames defined for this process?
2. How does the MCO notify enrollees of any denials of a request for expedited resolution?
3. Have there been any complaints by Medicaid enrollees that their requests for expedited appeals have not been acted upon timely (e.g., within three working days). If so, how many such complaints were received in the year under review?

Recordkeeping and reporting requirements (438.416)

1. How are Medicaid grievances and appeals registered and tracked for resolution? Is each grievance and appeal tracked through to resolution?
2. How often is Medicaid grievance and appeal information analyzed for trends? Who receives this analysis? Does the MCO provide any information to the State relative to its grievances and appeals?
3. How long are Medicaid grievance and appeal records retained?
4. To what extent is information on Medicaid enrollee grievances and appeals analyzed and included as part of your MCO's Quality Assessment and Performance Improvement Program?

Continuation of benefits while the MCO or PIHP appeal and the State Fair hearing are pending (438.420)

1. What happens to enrollee benefits once continuation of benefits has been denied by the MCO, and an appeal has been filed by the enrollee or the treating physician? Are there any mechanisms in place to continue the benefits pending the outcome of the appeal? If so, under what circumstances?

Utilization Management Staff

MCO interview participants should include the Medical Director, utilization management directors or managers, utilization management review staff, case managers or care coordinators, and any other individuals who have information pertinent to these regulatory provisions. [Note: This interview can be combined with the Medical Director interview or the Care Coordinators and Case Managers interview.]

The utilization management interview provides an opportunity to discuss with the MCO staff responsible for tracking and managing the utilization of MCO services. Through these interviews, the reviewer(s) will assess delivery network, service authorization; the use of practice guidelines, and grievances and appeals; and management of resources across all MCO network provider sites where enrollees receive health care.

Delivery network (438.206(b))

1. What procedures must a Medicaid enrollee follow if he/she wishes to receive a second opinion? For what types of services are second opinions available?

Coverage and authorization of services (438.210)

1. What types of services require pre-authorization?
2. What are the MCO's time frames for processing standard and expedited requests for service authorization?
3. How does the MCO monitor its compliance with these time frames? What sources of documentation exist to provide evidence of the monitoring by the MCO?
4. How often and under what circumstances are requesting providers consulted when the MCO makes service authorization decisions?
5. To what extent does the MCO assess the consistency of authorization decisions? How does the MCO do this?
6. What is the process when a decision is being made to deny authorization for a service? Who makes the decision to deny a request to authorize a service?
7. Describe the process for notifying the requesting provider and the enrollee of any decision to deny, limit, or discontinue authorization of services. What information is typically included in enrollee and provider notification? What are the MCO's time frames for notification?
8. How big of a problem is inappropriate use of emergency rooms by your Medicaid enrollees?
9. Has your MCO investigated a potential relationship between inappropriate emergency room use and enrollee access to routine and urgent care?
10. What was the volume of denied claims for emergency and post-stabilization services in the most recent year?

Grievance systems (438.228)

1. What types of services require pre-authorization?
2. Describe the process for notifying the requesting provider and the enrollee of any decision to deny, limit, or discontinue authorization of services. What information is typically included in enrollee and provider notification? What are the MCO's time frames for notification?
3. How does your MCO track requests for covered services that your MCO or its providers has denied?
4. What was the volume of denied request for services in the most recent year?

Application of practice guidelines (438.236(c))

1. What practice guidelines have your MCO adopted?

2. To what extent are your utilization management review guidelines (criteria) consistent with these practice guidelines? How do you promote or ensure consistency?
3. Describe how utilization management review guidelines (criteria) are modified to reflect the adoption or revision of practice guidelines. Are both sets of guidelines updated through the same process, at the same time?

Quality assessment and performance improvement program (438.240)

1. What information is analyzed to detect over- and under-utilization of services? Who is involved in the analysis and review of this information? Have any trends been identified? What are the typical follow-up actions taken when either condition is discovered?

Grievance system - General requirements (438.402)

1. Describe the appeals process and the role of utilization management staff in the resolution process. Elaborate on the particular steps, including time frames, in which utilization management staff is involved.
2. Is there a process in place for those instances when an enrollee's health condition requires expedited resolution of an appeal? Describe this process and its time frames.

Handling of grievances and appeals (438.406)

1. What MCO department or staff is responsible for assisting enrollees in using the MCO's appeal or grievance system, including completing forms, or taking other steps to resolve an appeal or grievance?
2. What are the qualifications and credentials of individuals who make decisions on grievances and appeals? How does the MCO ensure that these individuals:
 - were not involved in any previous level of review or decision-making; and
 - If deciding any of the following, have the appropriate clinical expertise in treating the enrollee's condition or disease.
 - (A) An appeal of a denial that is based on lack of medical necessity.
 - (B) A grievance regarding denial of expedited resolution of an appeal.
 - (C) A grievance or appeal that involves clinical issues?

Expedited resolution of appeals (438.410)

1. Is there a process in place for those instances when an enrollee's health condition requires expedited resolution of a grievance? Describe this process. What are the time frames defined for this process?
2. How does the MCO notify enrollees of any denials of a request for expedited resolution?

Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending (438.420)

1. What happens to enrollee benefits once continuation of benefits has been denied by the MCO, and an appeal has been filed by the enrollee or the treating physician? Are there any

mechanisms in place to continue the benefits pending the outcome of the appeal and if so, under what circumstances?

Medical Directors

The interview with the Medical Director provides an opportunity to assess MCO processes for authorizing services and coverage for those services. The interview will address such topics as provider involvement in the review of criteria used in the utilization management process, consistency between utilization management criteria and practice guidelines, and Quality Assessment and Performance Improvement efforts.[Note: This interview can be combined with the Utilization Management interview or the Care Coordinators and Case Managers interview.]

Coverage and authorization of services (438.210)

1. How does the MCO monitor its compliance with the State's time frames for processing standard requests for service authorization?
2. What are the MCO's standards for processing expedited requests for service authorization? How does the MCO monitor its compliance with these time frames?
3. Under what circumstances is there consultation with requesting providers when responding to service authorization requests?
4. How does the MCO ensure consistent application of criteria used in making service authorization decisions?
5. What mechanism does the MCO use to assure that 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 enrollees' condition or disease?
6. How are employees and any contractors used by the MCO to perform service authorization and utilization management financially compensated? Are they paid in any way other than on a straight salary or per case review basis? Do their financial compensation arrangements involve the use of any financial incentives?

Quality assessment and performance improvement program (438.240)

1. Does the MCO have any processes for reviewing claims, payment systems, encounter data, electronic health records, and medical records to assess utilization of services? Does the MCO utilize a health information exchange process? What reports on service utilization are regularly produced by these processes? What are the most recent findings with respect to over- and under-utilization?
2. How does your MCO define enrollees with "special health care needs"? How are these enrollees identified within your MCO?
3. How does your MCO assess the quality and appropriateness of care furnished to enrollees with special health care needs? Provide examples.

Case Managers and Care Coordinators

Case managers and care coordinators typically are among the few MCO staff with opportunity to interact closely and directly with Medicaid enrollees. These individuals are often responsible for guiding enrollees to the care and services available through their benefits and the provider network. These individuals play a key role in assisting enrollees in managing and maintaining their health and managing complex conditions. Interviewing these individuals will provide reviewers the opportunity to discuss topics surrounding MCO processes related to service availability, enrollee needs and special populations, and continuity and coordination of care. [Note: This interview can be combined with the Medical Director interview or the Utilization Management interview.]

Enrollee right to participate in decisions regarding his or her health care (438.100(b)(iv))

1. To what extent does the MCO allow enrollees to participate in care and treatment decisions? Describe some of the ways in which this is accomplished.

Furnishing of services and timely access (438.206(c))

1. To what extent are services offered through the MCO available to Medicaid enrollees and others coordinating care 24 hours per day, 7 days per week when medically necessary?
2. What types of services require pre-authorization?

Coordination and continuity of care (438.208)

1. Does this MCO screen Medicaid enrollees to identify those with special health care needs? If yes, how is this implemented?
2. How are Medicaid enrollees with special health care needs - including both any individuals with special health care needs identified by your MCO and any identified by the State Medicaid agency or its agent - identified and tracked within your MCO?
3. Does this MCO assess Medicaid enrollees with special health care needs? If yes, how are these activities conducted?
4. Does this MCO require written treatment plans to be developed for enrollees with ongoing special conditions that require a course of treatment or regular care monitoring? If yes, how is it decided which Medicaid enrollees will receive a written treatment plan?
5. If treatment plans are required by this MCO, how does the MCO ensure that treatment plans for individuals with special health care needs address the needs identified by the assessment?
6. Describe the treatment planning process for individuals with special health care needs and the process for determining and assuring appropriate use of specialists.
7. Within the last year, how many treatment plans have been developed? How many requests for treatment plans have been denied? What were the reasons for these denials? How many treatment plans have been denied?

8. What process(es) is/are used to coordinate services for enrollees? Are their different types of care coordination mechanisms for different types of enrollees? If so, how are these different and how do they work?
9. Who is responsible for coordinating the care of individuals with special health care needs?
10. What are the procedures for coordinating the services that the MCO furnishes to the enrollee with services the Medicaid enrollee receives from any other MCOs and PIHPs?
11. If the MCO establishes separate coordination of care for medical services and mental health and substance abuse services, how does the MCO ensure exchange of necessary information between providers?

Coverage and authorization (438.210)

1. What types of services require pre-authorization?

Providers and Contractors (as appropriate and time and resources permit)

Interviewing providers and contractors requires additional time and resources. However, it is an opportunity to obtain further information about MCO performance from those health care professionals and institutions that often serve as the first point of contact for Medicaid members and health care providers. Because of this, provider and contractor interviews should be considered as an optional component of this protocol - to be considered whenever there is a strong need for additional information and when time and resources permit. The interview participants should be selected from the provider network and should offer representative view of the breadth of the MCO's primary care, specialist, and institutional providers. These persons can often clarify issues pertaining to communication, traversing the system, assuring enrollee rights, and delivery of care and services to the enrolled population.

There are several ways to conduct the interview. The interview can be arranged with a group of individual health care practitioners and with a group of institution representatives. It can be coordinated as one interview for each group or as a combined group. Geographic location of providers should be considered, and conference calls are a viable option for conducting an interview of this type, and often preferred by providers as only a brief interruption in their daily activities. In order for this interview to be effective, reviewers should emphasize that this is an opportunity to provide insight on the MCO's performance and not an evaluation of the care and services offered to Medicaid enrollees.

Enrollee rights (438.10) and Enrollee information (438.100)

1. When the MCO's enrollees present for services, do they appear to have a clear understanding of their rights, responsibilities, and benefits? How to obtain services?
2. Does the MCO provide you with information on where to refer enrollees who are having difficulty understanding the materials that have been provided to them by the MCO ?
3. How often do you and your staff have to assist enrollees with understanding the materials provided by the MCO?

4. Does the MCO require providers to have access to oral interpreter services? Does the MCO provide your office with guidance or assistance in accessing interpreter services if necessary?

Enrollee rights to receive information on available treatment options (438.102) Provider-enrollee communications (438.100)

1. Does the MCO place any limits on your ability to counsel or advise a Medicaid enrollee on treatment options that may be appropriate for the enrollee's condition or disease?
2. Does the MCO encourage providers to share with enrollees information on available treatment options and alternatives? Does this include options and alternatives that are within as well as those outside the scope of the enrollee's benefits? If so, how does the MCO do this?

Availability of Services: Furnishing of services (438.206(c))

1. Are your hours of operation for Medicaid enrollees different from the hours of operation for other MCO enrollees? If so, why?

Practice guidelines (438.236)

1. Are affiliated providers/contractors consulted as practice guidelines are adopted and re-evaluated?
2. How does the MCO make providers/contractors aware of practice guidelines currently in use and those under consideration for adoption?

Expedited resolution of appeals (438.410)

1. Have there been any instances in the most recent year under review when the MCO took any punitive action against you for requesting an expedited resolution of an appeal on behalf of Medicaid enrollees or for supporting an enrollee's appeal?