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United States Government Accountability Office
Washington, DC 20548

December 8, 2004

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

Subject: *Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees*

The use of managed care within Medicaid, a joint federal-state program that finances health insurance for certain low-income families with children and individuals who are aged or disabled, increased significantly during the 1990s. By 2003, 59 percent of Medicaid beneficiaries were enrolled in managed care, compared with less than 10 percent in 1991.¹ Medicaid managed care, under which states make prospective payments to managed care plans to provide or arrange for all services for enrollees,² attempts to ensure the provision of appropriate health care services in a cost-efficient manner. However, because plans are paid a fixed amount regardless of the number of services they provide, managed care programs require safeguards against the incentive for some plans to underserve enrollees, such as by limiting enrollees' access to care. Access is also affected by other factors, such as physician location and willingness to participate in managed care plans. Safeguards to ensure enrollees have access to care could include requiring plans to maintain provider networks that provide enrollees with sufficient geographic access to providers or requiring

¹Managed care enrollment figures for 2003 include individuals enrolled in plans that provide both comprehensive benefits, such as managed care organizations (MCO), and limited benefits, such as prepaid ambulatory health plans (PAHP).

²Throughout this report we use the term enrollees to refer to all Medicaid beneficiaries, Medicare beneficiaries, and privately insured individuals who are enrolled in managed care plans.

managed care plans to develop and monitor certain quality indicators, such as enrollee satisfaction surveys or grievances.

The Balanced Budget Act of 1997 (BBA) gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans and also required the establishment of consumer protections for Medicaid managed care enrollees in areas such as access to and quality of care.³ In June 2002, the Centers for Medicare & Medicaid Services⁴ (CMS) issued final regulations for Medicaid managed care organizations (MCO) to implement these BBA requirements.⁵

The BBA directed us to examine the access and quality requirements applicable to MCOs operating under the Medicare program⁶ and to private sector MCOs to determine their relevance to the Medicaid MCOs.⁷ As discussed with the committees of jurisdiction, we examined the extent to which Medicaid MCO requirements specifically address the needs of enrollees who are low income, have special cultural needs (such as language differences), or have special health care needs (such as chronic illnesses or disabilities) in comparison to similar requirements applicable to Medicare and private sector MCOs.

To do this, we identified the requirements contained in CMS regulations for Medicaid MCOs that specifically address the accessibility or quality of health care services delivered to low-income and other special needs enrollees. We considered a requirement to specifically address these target groups if it referenced that group by name or otherwise targeted a need or characteristic unique to that group. We compared these specific requirements with comparable requirements applicable to MCOs operating under the Medicare program and in the private sector. Medicare MCO requirements are contained in CMS regulations and in CMS's supplemental guidance in the *Medicare Managed Care Manual*. Private sector MCO requirements and supplemental guidance are contained in manuals developed by two private accrediting organizations—the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We interviewed officials from CMS, NCQA, and JCAHO to clarify the requirements applicable to managed care plans and to identify any that specifically address a special needs enrollee group. We also interviewed officials from the National Academy for State Health Policy and reviewed literature on the use of quality assurance and access requirements in Medicaid managed care. We did not evaluate the implementation of these requirements by individual states or MCOs. We performed our work in two periods—from October 2003 through December 2003 and

³Pub. L. No. 105-33, § 4701, 111 Stat. 251, 489; § 4705(a), 111 Stat. at 498.

⁴CMS was previously known as the Health Care Financing Administration (HCFA). We use the term HCFA to refer to the agency prior to its renaming on July 1, 2001, and CMS for references to the agency after that date.

⁵67 *Fed. Reg.* 40989 (June 14, 2002).

⁶Medicare is the federal program that finances health coverage for individuals aged 65 and older, certain disabled individuals, and individuals with end-stage renal disease (ESRD). Medicare managed care plans are offered by private managed care organizations under contract with the Medicare program to provide care to Medicare beneficiaries.

⁷BBA, § 4705(c), 111 Stat. at 500.

from July 2004 through September 2004—in accordance with generally accepted government auditing standards.

Results in Brief

Medicaid MCO access and quality requirements specifically address the needs of managed care enrollees who are low income or have special cultural or health care needs, to an equal or greater extent than requirements applicable to Medicare and private sector MCOs. Regarding low-income enrollees, neither Medicare nor private sector requirements specifically address their needs as distinct from those of other enrollees. However, we identified one area that is key to access for low-income enrollees—transportation. Medicaid regulations and Medicare guidelines require that when developing their provider networks MCOs take into account the means of transportation—such as public transportation—enrollees use to access health care providers. No such explicit requirement applies to private sector MCOs. Regarding the cultural and language characteristics of enrollees, Medicaid regulations are more specific than Medicare and private accreditation requirements. While all requirements broadly state that services must be delivered in a “culturally competent manner,” only the Medicaid regulations require that the primary language spoken by each individual be identified at the time of enrollment and that each managed care enrollee be provided with the names of and non-English languages spoken by contracted health care providers in the enrollee’s service area. Additionally, Medicaid regulations require states to make oral interpretation services available and require that each MCO make these services available free of charge to each enrollee and potential enrollee. Regarding enrollees with special health care needs, Medicaid requirements are generally comparable to Medicare and private accreditation requirements. All require that individuals with special health care needs—such as chronic illnesses or disabilities—be identified and provided with appropriate services for managing these conditions.

CMS concurred with our findings.

Background

Since 1965, Medicaid has financed health care coverage for certain categories of low-income individuals, covering an estimated 53 million people in fiscal year 2002.⁸ States administer the program within broad federal guidelines and have considerable flexibility in designing certain aspects of the program, including eligibility, covered services, and provider payment rates.⁹ States generally cover Medicaid services for beneficiaries through two major financing approaches: traditional fee-for-service (FFS), in which the Medicaid program directly reimburses providers for care

⁸Categories of individuals eligible for Medicaid include pregnant women and children with family incomes below specific limits and individuals with limited income and assets who are age 65 or older or disabled.

⁹The federal share of Medicaid funding varies by state and is based on a state’s per capita income in relation to the national per capita income. By statute, the federal share of Medicaid expenditures across individual states may range from 50 to 83 percent.

provided to beneficiaries,¹⁰ and capitated managed care, in which the state prospectively pays MCOs a fixed monthly fee per enrollee to provide or arrange for most health care services.¹¹

Medicare is a federal program that primarily provides health care coverage for adults aged 65 and older.¹² Medicare beneficiaries can choose to receive covered services on an FFS basis or through a Medicare MCO if one offers a plan in the area where they live.¹³ In general, MCOs participating in the Medicare program receive prospective fixed monthly payments for each enrolled beneficiary in return for providing all Medicare-covered benefits, except hospice care, and complying with all program requirements. As of August 2004, 12 percent of Medicare beneficiaries (4.6 million) were enrolled in a managed care plan.

Several federal initiatives have been undertaken to promote quality within Medicaid and Medicare managed care. In 1991, HCFA began the Quality Assurance Reform Initiative to provide technical assistance to state Medicaid agencies aimed at improving the quality of their managed care programs. In 1996, the agency furthered these efforts with the Quality Improvement System for Managed Care (QISMC) initiative, which in part served to develop coordinated quality requirements for Medicare and Medicaid managed care plans and to assist the federal government and state agencies in effectively providing health care services to vulnerable populations. QISMC guidelines served as a program manual for Medicare managed care plans and were used by states at their discretion within their Medicaid programs.

In 1997, the BBA made significant revisions to Medicaid managed care. For example, the BBA provided states additional flexibilities in administering managed care programs, including the authority to require enrollment of certain beneficiaries in

¹⁰We define FFS systems to include traditional FFS, in which a provider bills the program for services provided to an eligible beneficiary, as well as primary care case management (PCCM) systems, in which a physician, physician group practice, or similar entity contracts with the state to locate, coordinate, and monitor primary health services for Medicaid beneficiaries for a nominal monthly, per capita case management fee (usually around \$3). Within PCCM, delivered services are typically reimbursed on an FFS basis.

¹¹States generally rely on two major types of managed care plans to provide health care services to their Medicaid beneficiaries: MCOs, which provide beneficiaries with a comprehensive range of services; and prepaid health plans, which include prepaid inpatient health plans and prepaid ambulatory health plans and provide a more limited array of services. Prepaid inpatient health plans are limited service plans that provide some coverage of a beneficiary's inpatient hospital or institutional care, such as a mental health plan; prepaid ambulatory health plans are plans that provide limited services, such as a dental plan, and do not cover any inpatient services.

¹²Certain individuals under 65 who are disabled or have ESRD are also eligible for the Medicare program. These beneficiaries represented about 15 percent of Medicare's 40 million beneficiaries in 2002.

¹³Information presented in this report reflects the Medicare + Choice regulations. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created the Medicare Advantage program, which will replace Medicare + Choice as the managed care program for Medicare. See Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176. Final regulations for the Medicare Advantage program had not been issued as of December 6, 2004.

managed care plans without seeking a waiver of certain statutory requirements.¹⁴ The act also provided additional safeguards for enrollees by requiring the establishment of new access and quality standards for MCOs. In June 2002, CMS issued final regulations for Medicaid managed care implementing the requirements of the BBA. The regulations include provisions to ensure that states consider the needs of low-income and other special needs populations when establishing specific requirements for managed care plans.

Private, commercial managed care plans can voluntarily seek the review of private accrediting organizations, such as NCQA and JCAHO, although such accreditation is generally not required to operate a health plan.¹⁵ These organizations review plans' adherence to their internally developed accreditation requirements, including measures of access and quality, and grant accreditation to plans that comply with these requirements, serving as a "seal of approval" on the quality of plan services. Both NCQA and JCAHO regularly update their accreditation requirements for MCOs as quality measurement techniques develop and advance. According to JCAHO and NCQA estimates, between one-third to one-half of managed care plans nationwide have obtained accreditation.

The various requirements for MCOs used by Medicaid, Medicare, and private sector accrediting organizations generally address similar aspects of enrollee access to and quality of care, including availability of services, coordination and continuity of care, quality or performance assessment and improvement, and enrollee appeals and grievances. In recognition of the similarities between public and private requirements, both Medicaid and Medicare allow information from private accreditation reviews to be used to assess plan compliance with certain comparable public sector requirements. For example, Medicare regulations allow Medicare-participating MCOs that have been accredited by federally approved accreditation organizations to be deemed compliant with certain Medicare requirements.¹⁶ For Medicaid, states are permitted to use information obtained from a Medicare or private accreditation review in place of the state's own review, as long as the Medicare or private accreditation requirements are comparable to the state's requirements.¹⁷ Medicaid regulations also allow certain managed care plans that have contracts with both Medicaid and Medicare to use their Medicare review to satisfy Medicaid external quality review requirements.

¹⁴Prior to BBA, states were required to obtain a federal waiver of certain statutory requirements, such as guaranteeing beneficiaries' freedom to choose among participating providers, before they could make managed care enrollment mandatory for Medicaid beneficiaries. BBA gave states the authority to make managed care enrollment mandatory for most beneficiaries more routinely through an amendment to their state Medicaid plan, but still requires states to seek waivers for mandatory managed care programs that enroll beneficiaries eligible for both Medicare and Medicaid (dual eligibles), Indians who are members of federally recognized tribes, and children with special needs.

¹⁵Certain purchasers of health coverage may require an MCO to be accredited. For example, according to NCQA, many states require health plans that serve state employees to earn accreditation.

¹⁶Accreditation can be used by a Medicare-participating MCO to receive deemed status in the following six categories: access to services; advance directives; antidiscrimination; confidentiality and accuracy of enrollee records; provider participation; and quality assurance. CMS continues to review the nondeemed areas such as grievance and appeals, beneficiary enrollment, and marketing.

¹⁷According to NCQA, 30 states recognize NCQA accreditation as sufficient to demonstrate health plan compliance with certain regulatory requirements.

Medicaid Access and Quality Requirements Specifically Address the Needs of Low-Income and Other Special Needs Enrollees to an Equal or Greater Extent Than Do Medicare and Private Sector Requirements

Medicaid MCO access and quality requirements address the needs of low-income and other special needs populations at least as specifically as do Medicare and private sector requirements. Regarding low-income enrollees, neither Medicare nor private sector requirements specifically reference low-income enrollees as distinct from other enrollees. However, one area that is key to low-income enrollees' access to care is transportation, and Medicaid and Medicare requirements explicitly target low-income enrollees' transportation needs. For enrollees with special cultural needs, Medicaid requirements are more specific than Medicare and private accreditation requirements. Medicaid requirements for enrollees with special health care needs are comparable to Medicare and private accreditation requirements. (Encl. I presents Medicaid, Medicare, and private accreditation requirements for MCOs that address the needs of low-income and other special needs populations.)

Low-Income Enrollees

While Medicaid by definition serves a primarily low-income population, its managed care requirements do not specifically reference low-income enrollees, similar to requirements applicable to Medicare and private sector MCOs. However, both Medicaid and Medicare requirements state that MCOs must consider access to transportation, which uniquely affects low-income enrollees. Specifically, Medicaid regulations require MCOs to consider the means of transportation ordinarily used by enrollees when developing their provider networks. Similarly, Medicare guidance specifies that MCOs must assess the means of transportation enrollees rely on, such as public transportation, when developing their provider networks. Private accreditation requirements specify that an MCO's provider network should accommodate the geographic distribution of its members, but do not explicitly require MCOs to take into account possible differences in access based on means of transportation.

Enrollees with Special Cultural Needs

Medicaid, Medicare, and private accreditation requirements all broadly state that MCOs must consider the cultural needs and preferences of enrollees. Medicaid regulations require that states ensure each MCO promotes the delivery of services in a culturally competent manner and provides communication materials in all of the prevalent languages within the MCO's service areas. Medicare regulations similarly state that each MCO must provide services in a culturally competent manner and require plans that cover service areas with a significant non-English-speaking population to provide written membership materials in the language of these populations. Medicare regulations also require that MCOs focus on racial and ethnic minorities in their quality assurance programs. In the private sector, NCQA accreditation requirements encourage MCOs to take into consideration enrollees' cultural needs when developing their provider network, and JCAHO accreditation requirements specify that communication between the managed care plan and its

enrollees should occur in the primary language of the enrollee whenever possible, either directly or through translation.

Beyond these broad requirements, Medicaid requirements further specify actions that must be taken to accommodate enrollees' language or cultural differences. Medicaid regulations are unique in their requirement that states' quality strategies include procedures to identify the race, ethnicity, and primary language of each managed care enrollee at the time of enrollment and to provide this information to the MCO. The regulations also require that the state, its contracted representative, or the MCOs inform enrollees of the non-English languages spoken by contracted health care providers. Additionally, under Medicaid regulations, states must make oral interpretation services available and each MCO must make these services available free of charge to each enrollee and potential enrollee.

Enrollees with Special Health Care Needs

Medicaid requirements concerning enrollees with special health care needs are comparable to Medicare and private accreditation requirements. In all cases MCOs are required to consider the needs of enrollees who may require alternative methods of communication, such as enrollees with visual impairments, and provide communication services necessary to accommodate these enrollees. Medicaid, Medicare, and private accreditation requirements also all require MCOs to identify enrollees with special health care needs and provide appropriate services for managing these conditions. However, the requirements differ in how those with special health care needs are defined. As a result, the populations targeted under each could vary depending on how the requirements are implemented.

Medicaid regulations specify that states must implement means to identify to MCOs those enrollees who have "special health care needs," as defined by the state. The BBA required the Department of Health and Human Services (HHS) to conduct a study of special needs populations,¹⁸ and in its report HHS focused on six populations as having special health care needs: children with special health care needs, children in foster care, individuals with mental illness or substance abuse, nonaged adults with disabilities or chronic conditions, older adults with disabilities, and individuals who are homeless.¹⁹ States may use this report as a guide but have discretion in how they define special needs. Once enrollees with special health care needs are identified, Medicaid regulations require that MCOs conduct an assessment of each special needs enrollee to identify conditions that require regular treatment and monitoring, and provide these enrollees with direct access to health care providers who specialize in that condition.²⁰ States also have the option under the Medicaid regulations of requiring MCOs to develop treatment plans for each enrollee identified as having special health care needs.

¹⁸BBA, § 4705(c)(2), 111 Stat. at 500.

¹⁹Department of Health and Human Services, *Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care* (Washington, D.C.: Nov. 6, 2000).

²⁰The term direct access describes an arrangement in which a managed care enrollee is not required to obtain a referral from a primary care physician or some other authorization prior to seeing a specialist.

Medicare regulations require MCOs to screen enrollees for “complex or serious medical conditions.” According to a CMS official, the agency has not identified the specific conditions considered to be complex or serious and instead MCOs are responsible for identifying these conditions. MCOs must then develop and implement a treatment plan for each enrollee identified as having a complex or serious condition, providing direct access to appropriate specialists.²¹

Private accreditation requirements specify that MCOs must identify enrollees’ health care needs and provide appropriate services for managing identified conditions. NCQA requirements state that MCOs must identify enrollees with special needs, focusing on those with chronic conditions and those with identifiable risk factors for specific health problems.²² NCQA also has requirements specifically focused on access to and quality of behavioral (mental) health services. MCOs must provide appropriate services to address identified conditions. However, NCQA does not require MCOs to develop individualized treatment plans or provide direct access to specialists. JCAHO requirements direct MCOs to ensure that care is planned, individualized, and appropriate for enrollees’ assessed health care needs, but JCAHO applies this standard broadly rather than requiring a separate focus on any specific group of enrollees. Under JCAHO requirements, MCOs are required to ensure proper integration and coordination of services but have flexibility in determining the best manner for achieving this and are not explicitly required to provide direct access to specialists.

Agency Comments

In its written comments on a draft of this report, CMS concurred with our findings. (See encl. II for a copy of CMS’s comments.)

We are sending copies of this report to the Administrator of CMS and upon request to other interested parties. In addition, this report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

²¹In August 2004, CMS issued a proposed rule to implement the Medicare Advantage program as established by MMA (See 69 *Fed. Reg.* 46866 (Aug. 3, 2004)). The proposed rule would eliminate the requirement that Medicare managed care plans identify individuals with complex or serious conditions and instead would generally require each plan to have a chronic care improvement program that identifies and monitors those with “multiple or sufficiently severe chronic conditions.” Additionally, the proposed rule would establish optional Medicare Advantage plans for special needs individuals that would limit enrollment to dual eligibles (Medicare beneficiaries who are also entitled to Medicaid), enrollees who are institutionalized (such as enrollees who reside in nursing homes), and enrollees who have a severe and disabling condition and meet requirements specified by CMS.

²²NCQA considers chronic conditions to include diseases or conditions that are usually of slow progress and long continuance (for example, hypertension, asthma, and diabetes) and which require ongoing care.

The information presented in this report was developed by Randy DiRosa, Elizabeth T. Morrison, Margaret Smith, and Kara Sokol. Please call me at (202) 512-7118 if you have any questions concerning this information.



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Enclosures

Private and Public Managed Care Access and Quality Requirements and Guidance that Address the Needs of Low-Income and Other Special Needs Enrollees

Table 1 presents public and private managed care access and quality requirements that target the needs of low-income and other special needs populations. Requirements for Medicaid MCOs are contained in CMS regulations published in the *Code of Federal Regulations*.²³ Requirements for Medicare MCOs are similarly contained in published regulations, as well as in supplemental guidance published by CMS in the *Medicare Managed Care Manual*.²⁴ Accreditation requirements and guidance for private sector MCOs are issued by NCQA and JCAHO.

Table 1: Public and Private Managed Care Access and Quality Requirements and Guidance Targeting Low-Income and Other Special Needs Enrollees

	Low-income enrollees	Enrollees with special cultural needs	Enrollees with special health care needs
Medicaid	In establishing and maintaining its provider network, each MCO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) must consider the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the plan. Each plan must also consider the geographic location of providers and Medicaid enrollees, considering distance, travel time, means of transportation ordinarily used by Medicaid enrollees, and whether provider locations provide physical access for enrollees with disabilities.	<p>The state, its contracted representative, or the managed care plans must provide enrollees with the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollees' service areas, including identification of providers that are not accepting new patients.</p> <p>State quality strategies must include procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO or PIHP for each Medicaid enrollee at the time of enrollment.</p> <p>The state must ensure that each MCO, PIHP, and PAHP participates in the state's efforts to promote the delivery of services in a</p>	<p>States' quality strategies must include procedures that assess the quality and appropriateness of care and services furnished to all enrollees and to enrollees with special health care needs.</p> <p>States must identify enrollees with special health care needs to MCOs, PIHPs, and PAHPs, as those enrollees are defined by the state. Each plan must implement mechanisms to assess each special needs enrollee in order to identify any ongoing special conditions that require treatment or regular care monitoring. States may require plans to develop treatment plans for enrollees with special health care needs. Health plans must have a mechanism to allow identified special needs enrollees direct access to a specialist, as appropriate for</p>

²³ 42 C.F.R. Part 438 (2003). CMS's *State Medicaid Manual* is being revised to include guidance for implementing requirements of the Medicaid managed care regulations.

²⁴ 42 C.F.R. Part 422 (2003); CMS's *Medicare Managed Care Manual*, www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp; downloaded on August 5, 2004. MMA replaced Medicare + Choice with the Medicare Advantage program. Final regulations establishing requirements for managed care plans under the Medicare Advantage program have not been issued. CMS's *Medicare Managed Care Manual* will be updated to include Medicare Advantage requirements once the final regulations are issued.

	Low-income enrollees	Enrollees with special cultural needs	Enrollees with special health care needs
		<p>culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.</p> <p>The state, MCOs, PIHPs, and PAHPs must make available written information in each prevalent non-English language in their service area.</p> <p>The state must make oral interpretation services available and must require each MCO, PIHP, and PAHP to make these services available free of charge to each enrollee and potential enrollee. This requirement applies to all non-English languages.</p> <p>The state must notify enrollees and potential enrollees and require each MCO, PIHP, and PAHP to notify its enrollees that oral interpretation is available for any language and that written information is available in prevalent languages and how to access these services.</p>	<p>the enrollees' condition.</p> <p>States must ensure that each plan has mechanisms to assess quality and appropriateness of care provided to special needs enrollees.</p> <p>Written material must 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.</p>
Medicare + Choice	<p>MCOs must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. Supplemental guidance states that MCOs must ensure that providers are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services and that MCOs must establish and maintain provider network standards that assess other means of transportation that members rely on such as public transportation.</p>	<p>Each MCO must ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.</p> <p>MCOs' quality assurance programs must include a separate focus on racial and ethnic minorities.</p> <p>For MCOs that serve areas with a significant non-English speaking population, marketing materials—including such things as membership communication materials and letters to members about changes in providers, premiums, and benefits—must be provided</p>	<p>Each MCO must have procedures that allow it to identify enrollees with complex or serious medical conditions, assess those conditions and use medical procedures to diagnose and monitor them on an ongoing basis, and establish and implement a treatment plan that is appropriate and includes an adequate number of direct access visits to specialists.</p> <p>MCOs other than preferred provider organizations (PPO) must conduct performance improvement projects; required clinical areas for performance improvement projects include prevention and care of acute and chronic</p>

	Low-income enrollees	Enrollees with special cultural needs	Enrollees with special health care needs
		in the languages of these individuals.	<p>conditions, high-volume services, high-risk services, and continuity and coordination of care.</p> <p>Supplemental guidance states that MCOs must ensure that all services, both clinical and nonclinical, are accessible to all enrollees, including those with limited reading skills and hearing incapacity.</p>
NCQA	<p>The organization ensures that its network has sufficient numbers and types of primary care and specialty care practitioners.</p> <p>The organization has quantifiable and measurable standards for the number and geographic distribution of primary care and specialty care practitioners.</p>	The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	<p>The MCO, which possesses data about the health status of its enrollees and which has a responsibility for meeting their health needs, actively intervenes to assist its enrollees and practitioners in managing chronic conditions.</p> <p>The MCO identifies the two chronic conditions that its disease management programs address. Annually, the MCO identifies enrollees who qualify for its disease management programs and provides eligible enrollees with written program information regarding how to use the services.</p> <p>The MCO identifies specific enrollees who, according to demographic and other identifiable health factors, may be at risk for specific health problems and urges them to use appropriate health promotion and prevention services. Supplemental guidance provides examples of how MCOs may target their health promotion and prevention services, including sending mammogram reminders to all women aged 50 and older and reminders to individuals with chronic diseases to get influenza and pneumonia immunizations.</p> <p>The MCO has standards for behavioral health access to</p>

	Low-income enrollees	Enrollees with special cultural needs	Enrollees with special health care needs
			<p>(1) care for a non-life-threatening emergency within 6 hours, (2) urgent care within 48 hours, and (3) an appointment for a routine office visit within 10 business days.</p> <p>The MCO collaborates with behavioral health specialists and uses information at its disposal to coordinate medical and behavioral (mental) health care.</p> <p>Enrollees undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the current period of active treatment or for up to 90 calendar days, whichever is shorter.</p> <p>The organization provides translation services within its enrollee services telephone function based on the linguistic needs of enrollee. Supplemental guidance states that this may include installing TDD/TYY lines.</p>
JCAHO	<p>Member health care services provided throughout the network are readily available, accessible, and appropriate to the scope and levels of care required by the member population.</p> <p>The network accommodates the geographic distribution of its members.</p>	<p>The managed care network communicates with members. Supplemental guidance states that verbal and written communication should occur in the primary language of the member whenever possible, either directly or through translation.</p> <p>Health care services provided are appropriate to the health care needs, as influenced by sociocultural characteristics, of the population served. Supplemental guidance states that sociocultural characteristics may include age, gender, years of schooling, marital status, ethnicity, nationality, sexual orientation, linguistic group, and religious affiliation.</p>	<p>Health care services are appropriate in scope to meet the health care needs of the population served.</p> <p>The network's preventive services are appropriate to the needs of the community or population served. Supplemental guidance states that MCOs should assess the population served and use this assessment to determine the prevalence of important risk factors, chronic conditions, communicable and environmentally induced health problems, and diseases.</p> <p>The network determines and provides the appropriate health care disciplines and specialists to meet enrollee health care needs.</p>

	Low-income enrollees	Enrollees with special cultural needs	Enrollees with special health care needs
		<p>Education provided [to enrollees] supports active member participation in health care and decision making about health care options and their consequences.</p> <p>Supplemental guidance states that this provision is intended to include consideration of variables such as members' beliefs, values, literacy, and language.</p>	<p>The network ensures that assessments appropriate to the enrollees' health care needs are conducted, and that assessment scope and intensity are appropriate to the enrollees' health care needs.</p> <p>The network has a process to ensure that care is planned, individualized, and evaluated.</p> <p>Enrollees are informed of specific health care needs that require follow-up.</p> <p>The network communicates with enrollees. Supplemental guidance states this includes addressing the needs of enrollees with hearing, speech, and visual impairments.</p>

Sources: CMS, NCQA, and JCAHO.

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC - 3 2004

TO: Kathryn G. Allen
Director, Health Care –Medicaid
And Private Health Issues

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator

SUBJECT: Government Accountability Office Draft Report: *“Medicaid Managed Care: Access and Quality Requirements Specific to Low Income and Other Special Needs Enrollees (GAO-04-1052R)”*

Thank you for the opportunity to review and comment on the draft report entitled *“Medicaid Managed Care: Access and Quality Requirements Specific to Low Income and Other Special Needs Enrollees (GAO-04-1052R)”*.

The Centers for Medicare & Medicaid Services (CMS) concurs with GAO’s findings that Medicaid access and quality requirements specifically address the needs of low income and other special needs enrollees to an equal or greater extent than other programs. It is important to note that the Medicaid regulations accomplish this while giving each State the flexibility to determine how to comply in ways that best meet the needs and circumstances within the State

The report does not contain any recommendations nor does it reference the Medicaid payment rules which are based on the development of actuarially sound rates in risk contracts. States account for the potentially higher costs of individuals with special health care needs in setting appropriate capitation rates for managed care entities.

Again, thank you for the opportunity to review this draft report.

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