

Comment: One commenter suggested expanding the protocol's activities to include the review of training curricula and materials on cultural and linguistic competency, including the scope and depth of the training, its frequency, and extent of staff attendance; the procedures for the translation and testing of enrollee informational materials; and arrangements with community-based organizations representing relevant ethnic groups.

Response: We disagree with the commenter. Our protocol addresses the extent to which an MCO/PIHP complies with the regulatory provisions that implement the Medicaid managed care sections of the BBA. The Medicaid managed care final rule, at § 438.206(c)(2), requires that MCOs/PIHPs participate in the State's efforts to promote the culturally competent delivery of services. Therefore, the protocol specifies a review of documents for evidence of the MCO's/PIHP's participation in the relevant State efforts. The inclusion of additional requirements not required by regulation within the protocol would be inappropriate.

10. Coordination & Continuity of Care

Comment: One commenter recommended that the review of coordination and continuity of care include interview questions regarding the provision of any specialty care services currently not provided in-network, and MCO efforts to make these services available in-network. The commenter also suggested that the interview questions be expanded to inquire what proportion of Medicaid enrollees with special health care needs have a person or entity formally designated as primarily responsible for coordinating their health care services.

Response: We agree, in part, with the commenter. Consequently, we have added an interview question for the organization leaders to inquire about the provision of any specialty care services currently not provided in-network. We have not added questions about MCO or PIHP efforts to make these services available in-network because it is not clear whether or not it is always necessary that all specialty services be provided by in-network providers. We have added additional potential interview questions for enrollee services staff to determine what proportion of Medicaid enrollees with special health care needs have a person or entity formally designated as primarily responsible for coordinating their health care services.

Comment: One commenter believes the protocol should differentiate

between gatekeeping activities that are involved with utilization control and care coordination and case management functions that are related to supporting service access and coordination. The commenter believes further that reviewers should consider the MCOs' scope of responsibility for EPSDT case management, and how these services are provided or referrals are made.

Response: We agree with the commenter that a State may want to differentiate between care coordination models. In so doing, a State may decide to explicitly address care coordination for EPSDT care management. We specify in the protocol that MCOs/PIHPs may establish different coordination mechanisms, and in monitoring for compliance with the requirements for care coordination, direct the reviewers to obtain the State's requirements for MCO/PIHP care coordination programs.

Comment: One commenter recommended that the interview protocol address how and who conducts the MCOs' health screens; how the MCO assesses enrollee needs and determines if the provider is qualified to perform the assessment; how enrollees access case management services; how an enrollee's need for a treatment plan is determined; and how the providers are informed of the process. The commenter also suggested additional interview questions to address the number of treatment plans developed by categories of individuals, the number of denied requests for treatment plans and the reason for denial, and the number of treatment plans denied.

Response: The protocol includes interviewer questions for the case managers and care coordinators and for the enrollee services staff regarding the implementation of health screens, the conduct of health assessments for Medicaid enrollees, processes for care coordination, and procedures to determine how an enrollee's need for a treatment plan is determined. The protocol's interview questions for the provider/contractor services staff probe how providers are made aware of and are involved in procedures for assessments, treatment planning, and care coordination. We agree with the commenter regarding the need to explore the MCO's/PIHP's treatment planning. We have revised the protocol to include a series of questions for the case managers and care coordinators concerning the number of treatment plans developed, the number of denied requests for treatment plans and the reason for denial, and the number of treatment plans denied. However, our revision will not include a review of the treatment plans by categories of

individuals. We do not require specific categories and, therefore, have no standard against which to measure the MCO's/PIHP's performance.

11. Prior Authorization

Comment: One commenter believes the protocol should include a review of prior authorization procedures and policies and a determination of their reasonableness, reflection of good medical practice, and timely application. The commenter suggested reviewers monitor the number of and reasons for delayed expedited requests, and the health consequences associated with prior authorization delays and denials of expedited authorizations. The commenter further believes the MCOs' informal communications with providers should be monitored, including the handling of provider telephone inquiries, resulting changes to the course of treatment, and provision of enrollee notice and appeal rights.

Response: We agree with the commenter regarding the need to determine compliance with the requirement for timely prior authorization decisions, and therefore have included in the protocol document review and interview questions to determine compliance. However, the regulations include no standards for the reasonableness of the policies and procedures or for their reflection of good medical practice; these issues are therefore beyond the scope of the protocol that is designed to assess compliance with the Medicaid managed care regulatory requirements.

We also agree with the commenter's suggestion to review the number and reasons for delayed expedited requests. We have revised the document review for service authorizations to include the review of tracking logs or other authorization record-keeping documents to address number and reasons for delayed expedited requests.

We do not agree with the suggestion to monitor health consequences associated with prior authorization delays and denials of expedited authorizations. We believe that determinations on whether health consequences were due to authorization delays or denials, or to the normal progression of the enrollees' health condition would be subjective. Further, States are required to maintain records of grievances and appeals and review this information as part of the State quality strategy. If enrollees' health outcomes are adversely affected by the MCO's/PIHP's handling of service authorization requests, this should become evident to the State through this grievance and appeals review.