CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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I. SUMMARY OF CHANGES:

CLARIFICATION – EFFECTIVE DATE: Not Applicable.

Section 120.2 - Access and Availability Rules for Coordinated Care Plans -

Added a sentence to the third bullet requiring primary care physicians to have backup for absences.

Added text to the fifth bullet regarding the provision of services in a culturally sensitive and accessible manner to those who may not speak English well, or with hearing or vision impairments.

Section 120.3 - Rules for All M+C Organizations to Ensure Continuity of Care - Added text to fourth bullet requiring the M+C organization to follow up on unsuccessful attempts to contact an enrollee after 90 days to obtain an initial health assessment.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/120.2/Access and Availability Rules for Coordinated Care Plans
R	4/120.3/Rules for All M+C Organizations to Ensure Continuity of Care

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

120.2 - Access and Availability Rules for Coordinated Care Plans

(Rev. 49, 04-09-04)

An M+C organization may specify the providers through whom enrollees may obtain services if it ensures that all covered services, including additional or supplemental services contracted for, by, or on behalf of Medicare enrollees, are available and accessible under the coordinated care. To accomplish this, the organization must meet the following requirements:

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care. In other words, the M+C organization must ensure that providers are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services. For example, a commonly used service must be available within 30 minutes driving time. Of course, longer travel times are permissible as long as they are based on location (such as a rural area) and/or are established and based on the routine patterns of care that are available in the geographic area.

- Establish and maintain provider network standards that:

    - Define the types of providers to be used when more than one type of provider can furnish a particular item or service;

    - Identify the types of mental health and substance abuse providers in their network;

    - Specify the types of providers who may serve as a member's primary care physician; and

    - Assess other means of transportation that members rely on such as public transportation.

- Employ written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, make these standards known to all first tier and downstream providers, continuously monitor its provider networks' compliance with these standards, and take corrective action as necessary. These standards must ensure that the hours of operation of the M+C organization's providers are convenient to, and do not discriminate against, members. The M+C organization must also ensure that, when medically necessary, services are available 24 hours a day, 7 days a week. *This includes*

requiring primary care physicians to have appropriate backup for absences The standards should consider the member's need and common waiting times for comparable services in the community. (Examples of reasonable standards for primary care services are: (1) Urgent but non-emergent - within 24 hours; (2) Non-urgent, but in need of attention - within one week; and (3) Routine and preventive care - within 30 days.)

Establish, maintain, and monitor a panel of primary care providers from which the member may select a personal primary care provider. All M+C plan members may select and/or change their primary care provider within the plan without interference. The M+C organizations that require members to obtain a referral before receiving specialist services must ensure that their M+C plans have a mechanism for assigning primary care providers to members who do not select a primary care provider.

- Provide or arrange for necessary specialist care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. The M+C organization must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs.

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency*, limited* reading skills*, hearing incapacity, or* those with diverse cultural and ethnic backgrounds. *Examples of how an M+C organization can meet these accessibility requirements include provision of translator services, interpreter services, teletypewriters or TTY connections.*

- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management that allow for individual medical necessity determinations.

- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with the requirements that are discussed below in §130.

- Ensure that for each M+C plan, the M+C organization has in effect procedures that:

    - Identify individuals 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;
  - Includes an adequate number of direct access visits to specialists;
  - Is time specific and updated periodically;
  - Ensure coordination among providers; and
  - Considers the beneficiary's input.

120.3 - Rules for All M+C Organizations to Ensure Continuity of Care

(Rev. 49, 04-09-04)

The M+C organization must ensure continuity of services through arrangements that include, but are not limited to the following:

- Implementing policies that specify under what circumstances services are coordinated and the methods for coordination. The policies should specify whether the services are coordinated by the enrollee's primary care provider or through some other means.
- Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer.
- Establishing coordination of plan services that integrate services through arrangements with community and social service programs generally available through contracting or non-contracting providers in the area served by the M+C plan, including nursing home and community-based services.
- Developing and implementing procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that:
  - The M+C organization makes a good faith effort to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment ***and follows up on unsuccessful attempts to contact an enrollee****;*
  - Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

    - There is appropriate and confidential exchange of information among provider network components.

- Utilizing procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

- Employing systems to address barriers to enrollee compliance with prescribed treatments or regimens.
