Table 1. Network Provisions

State	Primary care provider standards			Specialty care provider standards			Specific oral health network requirements	OB/GYN network requirements	Women's preventive health requirements#	Designated centers of excellence	Cultural competency requirements	Network language services	Network disability services	Social service referral capabilities or affiliations	Other notable network and access requirements
	General ratio	*Specific pediatric ratio*	*Other*	*General ratio*	*Pediatric*	*Other*									
AZ	X[1]		X[2]					X[3]		X[4]	X[5]			X[6]	
CO			X[7]			X[8]					X[9]	X[10]	X[11]	X[12]	X[13]
CT*			X[14]			X[15]	X[16]				X[17]			X[18]	
FL	X[19]	X[20]			X[21]		X[22]	X[23]	X[24]		X[25]	X[26]			X[27]
IL	X[28]					X[29]	X[30]	X[31]	X[32]		X[33]	X[34]		X[35]	X[36]
KY	X[37]				X[38]						X[39]				X[40]
MD**			X[41]			X[42]			X[43]		X[44]			X[45]	
MA^	X[46]							X[47]	X[48]		X[49]	X[50]	X[51]	X[52]	
MN			X[53]					X[54]			X[55]	X[56]	X[57]		X[58]
MO^			X[59]			X[60]	X[61]				X[62]			X[63]	
NJ	X[64]		X[65]		X[66]		X[67]	X[68]	X[69]	X[70]	X[71]	X[72]	X[73]	X[74]	X[75]
OH	X[76]	X[77]			X[78]	X[79]	X[80]	X[81]			X[82]				
PA			X[83]			X[84]	X[85]	X[86]	X[87]	X[88]	X[89]	X[90]		X[91]	
RI^			X[92]						X[93]		X[94]		X[95]	X[96]	X[97]
SC			X[98]			X[99]					X[100]			X[101]	
TN	X[102]			X[103]					X[104]	X[105]	X[106]				
VA^			X[107]								X[108]				X[109]
WA			X[110]					X[111]	X[112]	X[113]	X[114]	X[115]		X[116]	
WV									X[117]		X[118]			X[119]	
Total	**8/19**	**2/19**	**12/19**	**1/19**	**4/19**	**8/19**	**7/19**	**9/19**	**10/19**	**5/19**	**19/19**	**8/19**	**5/19**	**13/19**	**8/19**

Notes:

* Connecticut operates a single Administrative Service Organization for physical health, which is the sole Contractor and provider of services in the state, and thus, their model contract does not provide for some of the network requirements that would be found in typical managed care contracts.

**** Maryland's boilerplate contract language is based heavily on and structured upon MD's regulations regarding managed care; therefore the footnotes below reflect regulatory citations.

Women's Preventive Health requirements refer to the ACA's requirement that women be offered coverage for at least one annual well-woman visit that women can use to obtain all of the preventive services that are recommended, including prenatal care. These services may, but are not required to, be performed by an OBGYN. Thus, the well-women preventive services are categorized separately from network OBGYN standards.

^ This state had only published an RFP for its contracts so the chart reflects provisions of the RFP instead of actual contract language.

All data in the footnotes is actual boilerplate language from the contracts and RFPs unless otherwise noted.

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[1] AZ Model Contract Sec. D. 29. PRIMARY CARE PROVIDER STANDARDS. … AHCCCS shall inform the Contractor when a PCP has a panel of more than 1,800 AHCCCS members, to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis.

[2] AZ Model Contract Sec. D. 29. PRIMARY CARE PROVIDER STANDARDS. The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this Contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwifes; or physician's assistants [42 CFR 438.206(b)(2)].

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards, when determining the appropriate number of its members to be assigned to a PCP. The Contractor shall adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. AHCCCS shall inform the Contractor when a PCP has a panel of more than 1,800 AHCCCS members, to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis.

[3] AZ Model Contract Sec. D. 31. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS The Contractor shall have adequate written procedures regarding referrals to specialists, to include, at a minimum, the following: … 5. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners within the scope of their practice.

[4] AZ Model Contract Sec. D. 75. Value-Based Purchasing. Centers of Excellence: Centers of Excellence are facilities that are recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Identification of a Center of Excellence should be based on criteria such as procedure volumes, clinical outcomes, and treatment planning and coordination. Identification of appropriate conditions and/or procedures most suitable to a relationship with a Center of Excellence should be based on analysis of the Contactor's data which demonstrates a high degree of variance in cost and/or outcomes. To encourage Contractor activity which incentivizes utilization of the best value providers for select, evidenced based, high volume procedures or conditions, the Contractor shall submit a Centers of Excellence Report annually to AHCCCS, DHCM, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The report shall incorporate the CYE 17 implementation of one to two contracts with either the Centers of Excellence identified in the CYE 16 Executive Summary and/or other existing Centers of Excellence based on the criteria above. The Contractor shall identify the Centers of Excellence under contract in CYE 17 and, if different from those identified in the CYE 16 Executive Summary, shall include a description as to how these Centers were selected. Value Based Providers/Centers of Excellence Report The Centers of Excellence Report shall outline the Contractor's process to develop, maintain and monitor activities for Centers of Excellence and include at a minimum: 1. Thorough description of the Contractor's initiatives to encourage member utilization, 2. Goals and outcome measures for the Contract Year, 3. Description of monitoring activities to occur throughout the year, 4. Evaluation of the effectiveness of the previous year's initiatives, 5. Summary of lessons learned and any implemented changes, 6. Description of the most significant barriers, 7. Plan for next Contract year.

[5] AZ Model Contract Sec. D. 19. CULTURAL COMPETENCY The Contractor shall implement a program to serve members in a culturally competent manner which takes into account the cultural and ethnic diversity of the Contractor's population and meets the requirements of ACOM Policy 405. The Contractor shall develop and implement a Cultural Competency Plan which meets the requirements of ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall ensure the Plan addresses cultural considerations for those with Limited English Proficiency and diverse cultural and ethnic backgrounds, for all services and settings [42 CFR 438.206(c)(2)].

[6] AZ Model Contract Sec. D. 26. Network Development. Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-For-Service rate for Primary Care services. Contracts must stipulate that: 1. Only those members who request a homeless clinic as a PCP may be assigned to them; and 2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services. The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization, and resolving claims issues.

[7] CO Rocky Mountain HMO FY 2017-2018 Contract (hereafter CO HMO Contract). Sec. 4.1.4. The Contractor shall ensure that its PCMP network is sufficient to meet the requirements for every Member's Access to Care, to serve all Member's primary care needs and allow for adequate Member freedom of choice amongst PCMPs and providers during the Initial Phase and Expansion Phase.

[8] CO HMO Contract. Sec. 4.1.6. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include, but are not limited to: 4.1.6.1. The physically or developmentally disabled. 4.1.6.2. Children and foster children. 4.1.6.3. Adults and the aged. 4.1.6.4. Non-English speakers. 4.1.6.5. Members with complex behavioral or physical health needs. 4.1.6.6. Members with Human Immunodeficiency Virus (HIV). 4.1.6.7. Members who are released from the Colorado Department of Corrections (DOC) or county jail system.

[9] CO HMO Contract. Sec.5.2.3. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: 5.2.3.3.2. Training on providing culturally competent care.
Sec. 6.4.3.2.3. The Contractor shall provide training related to special populations and barriers to care they may encounter due to socio-economic, cultural or disability status to all of its new clinical staff members. The Contractor shall provide updated training to all staff members as needed to address changes in training, to address issues that arise in relation to special populations or as requested by the Department.

6 CO HMO contract referencing Colo. Code Regs. § 1011-2:VI. C. In order to increase access to care to enrollees, HMOs are encouraged to develop community outreach efforts, including but not limited to: 1. Making provisions for delivery of health care services, including community-based services, to persons with disabilities and chronic illnesses, and to high risk or underserved populations; 2. Establishing ongoing collaborative arrangements with public health services, school-based health centers, community clinics, social service agencies, or other health related services or agencies; and 3. Developing culturally competent systems of care.

[10] CO HMO Contract Sec 4.1. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include, but are not limited to: … (4) Non-English speakers…

[11] CO HMO Contract Sec 4.1. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include, but are not limited to: (1) The physically or developmentally disabled. (2) Children and foster children. (3) Adults and the aged. (4) Non-English speakers. (5) Members with complex behavioral or physical health needs. (6) Members with Human Immunodeficiency Virus (HIV). (7) Members who are released from the Colorado Department of Corrections (DOC) or county jail system.
Sec. 6.4.3.2.3. The Contractor shall provide training related to special populations and barriers to care they may encounter due to socio-economic, cultural or disability status to all of its new clinical staff members. The Contractor shall provide updated training to all staff members as needed to address changes in training, to address issues that arise in relation to special populations or as requested by the Department.

[12] CO HMO Contract Sec. 6.4. The Contractor shall develop a formal system of care coordination for its Members. This formal system shall have the following characteristics: … The ability to link Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports. This ability to link may range from being able to provide Members with the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.

[13] CO HMO Contract Sec 4.1. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include, but are not limited to: (1) The physically or developmentally disabled. (2) Children and foster children. (3) Adults and the aged. (4) Non-English speakers. (5) Members with complex behavioral or physical health needs. (6) Members with Human Immunodeficiency Virus (HIV). (7) Members who are released from the Colorado Department of Corrections (DOC) or county jail system.

[14] CT General ASO. Sec. P.5. The Contractor shall assist the Department in addressing deficiencies in the CMAP Provider Network by developing and maintaining the provider network in geographic areas that do not provide adequate access to sufficient providers in a range of types and specialties to support adequate access to covered services. Specifically, the Contractor shall: P.5.1.1 . Encourage the use of provider outreach activities, such as scheduled office visits, recruiting and information stations at professional meetings, sponsoring of educational activities; P .5.1.2. Work with trade organizations and licensing boards to actively recruit providers; P.5.1.3. Work with existing CMAP providers to expand existing capacity and add new support services; P.5.1 .4. Identify potential providers and provide them with information and technical assistance regarding the provider enrollment process and provider service and performance standards to support participation as a network provider; and P.5.1.5. Coordinate with the Department's MMIS Unit and the Department as necessary to facilitate enrollment of new providers and identify impediments to enrollment.

[15] CT General ASO. Sec. P.5. The Contractor shall assist the Department in addressing deficiencies in the CMAP Provider Network by developing and maintaining the provider network in geographic areas that do not provide adequate access to sufficient providers in a range of types and specialties to support adequate access to covered services. Specifically, the Contractor shall: P.5.1.1 . Encourage the use of provider outreach activities, such as scheduled office visits, recruiting and information stations at professional meetings, sponsoring of educational activities; P .5.1.2. Work with trade organizations and licensing boards to actively recruit providers; P.5.1.3. Work with existing CMAP providers to expand existing capacity and add new support services; P.5.1 .4. Identify potential providers and provide them with information and technical assistance regarding the provider enrollment process and provider service and performance standards to support participation as a network provider; and P.5.1.5. Coordinate with the Department's MMIS Unit and the Department as necessary to facilitate enrollment of new providers and identify impediments to enrollment.

[16] CT operates a separate Dental ASO. CT General ASO Sec. L.1. The Contractor shall coordinate the health care needs of individuals with the Dental Health Partnership (CT DHP). Except as otherwise identified in this section, care management for dental health services for all members will be managed by the dental health ASO and dental services shall be managed by the dental health ASO.

[17] CT General ASO. Sec. E.5.1.2. Cultural Competency: All Intensive Care Management staff will be trained to enhance cultural awareness and knowledge of cultural and ethnic influences. Cultural sensitivity training will include exercises in empathy, interpersonal communication, appropriateness, and respect as well as assessment, diagnostic and clinical skills. A cultural competency self-study and testing will be required for staff.
Sec. Q.2.3. Ensure that Member information is clearly communicated in a manner that is culturally sensitive.

[18] CT General ASO. Sec. E.7. For Intensive Care Management Program, Contractor must have a strategy for communication with the member, service and support providers, local social and community service agencies, and the member's family and key supports.
Sec. M. COORDINATION WITH OTHER STATE AGENCIES; AND HOME AND COMMUNITY BASED WAIVER PROGRAMS . M.1. The Contractor shall coordinate with the following agencies. This shall include, but not be limited to referring potential clients to these programs in order to maximize community-based care: The Department of Children and Families (DCF) with respect to children involved in the care and custody of DCF; and The Departments of Developmental Services (DDS) and Mental Health and Addiction Services (DMHAS) with respect to the management of services for individuals participating in DDS or DMHAS administered Home and Community Based Waiver (HCBW) programs. The Contractor shall be required to coordinate with HCBW programs administered by the Department including the Acquired Brain Injury waiver program, the Connecticut Home Care Program for Elders, the Personal Care Assistance waiver, the Money Follows the Person project, and any other HCBW waiver programs that may be established by the Department during the period of this Contract. The Contractor shall be required to document referred members who could potentially benefit from waiver participation.

[19] FL MMA Exhibit II-A, Section VI, MMA Provider Network Standards Table. 1 PCP : 1,500 enrollees. The Managed Care plan shall have at least one (1) FTE PCP in each of the following four (4) specialty areas within the geographic access standards indicated above: (1) Family Practice; (2) General Practice; (3) Pediatrics; and (4) Internal Medicine.

[20] FL MMA Exhibit II-A, Section VI, MMA Provider Network Standards Table. 1 PCP: 1500 enrollees

[21] FL MMA Exhibit II-A, Section VI, MMA Provider Network Standards Table. For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee’s residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

[22] FL MMA Exhibit II-A, Section VI, MMA Provider Network Standards Table. Dentist, 1:1500 enrollees. Oral Surgery, 1:20,600 enrollees. The Managed Care Plan shall provide at least one (1) FTE PDP per service area including, but not limited to, the following broad specialty areas: (a) General dentist; and (b) Pediatric dentist.

[23] FL MMA Exhibit II-A, Section VI, MMA Provider Network Standards Table. OBGYN provider ratio of 1:1500 enrollees.

[24] FL MMA Exhibit II-A, Section VI. The Managed Care Plan shall enter into provider contracts with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure: Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist; and that low-risk enrollees have access to certified nurse midwife services or licensed midwife services.
[25] FL MMA Exhibit II-A, Sec. V.D. If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.
[26] FL MMA Exhibit II-A, Sec. V.D. If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.
[27] FL MMA Exhibit II-A, Section VI. **Essential Providers**: Pursuant to s. 409.975(1)(b), F.S., certain providers are statewide resources and essential providers for all managed care plans in all regions. The Managed Care Plan shall include these essential providers in its network, even if the provider is located outside of the region served by the Managed Care Plan; **Subspecialists**: The Managed Care Plan shall enter into provider contracts with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following: (1) At least one (1) of the network infectious disease specialists have expertise in HIV/AIDS and its treatment and care; (2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist; and (3) In accordance with s. 641.31, F.S., low-risk enrollees have access to certified nurse midwife services or licensed midwife services, licensed in accordance with Chapter 467, F.S.; **Public Health Providers**: The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with the local County Health Departments (CHDs) to provide services which may include, but are not limited to, family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and post-natal screenings. The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.
[28] IL Model Contract. Sec. 5.8.8. 1:1800 enrollees.
[29] IL Model Contract. Sec. 5.7.10 Specialty care. Contractor shall establish a comprehensive network to ensure the availability and accessibility of specialists and subspecialists to meet the needs of Enrollees. Care Coordinators shall have the authority to authorize services and will not require approval by Contractor's medical director for the majority of services in accordance with recognized Medically Necessary criteria. For Enrollees with special healthcare needs who require an ongoing course of treatment or regular care monitoring, Contractor must provide mechanism for Enrollee to directly access specialists, as appropriate for the conditions and needs.
[30] IL Model Contract. Sec. 5.8.1. Dental access for Children. Contractor shall ensure an Enrollee has access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)– minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.
[31] IL Model Contract. Sec 5.8.1. Contractor shall ensure an Enrollee has access to at least two (2) OB/GYN Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) OB/GYN Provider within a sixty (60)–mile radius of or sixty (60)– minute drive from the Enrollee's residence.
[32] IL Model Contract. 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning.
[33] IL Model Contract. Sec. 2.7. Contractor shall implement a Cultural Competence plan, and Covered Services shall be provided in a culturally competent manner by ensuring the Cultural Competence of all Contractor staff, from clerical to executive management, and Providers. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards);
Contractor's Cultural Competence plan shall address the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence plan shall, at a minimum, address the following: involvement of executive management and Providers in the development and ongoing operation of the Cultural Competence plan; the individual executive employee responsible for executing and monitoring the Cultural Competence plan; the creation and ongoing operation of a committee or group within Contractor to assist Contractor to meet the cultural needs of its Enrollees. This committee shall: be reflective of the geographical and cultural groups served by Contractor, and at minimum have fifty-one percent (51%) of its committee members be Enrollees or community-based participants; the assurance of Cultural Competence at each level of care; indicators within the Cultural Competence plan that Contractor will use as benchmarks toward achieving Cultural Competence; Contractor's written policies and procedures for Cultural Competence; Contractor's strategy and method for recruiting staff with backgrounds representative of Enrollees served; the availability of interpretive services; Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation; Contractor's ongoing strategy and method to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities and its operation; Contractor's ongoing strategy and method to provide services for home-bound Enrollees and the strategy's operation; Contractor's ongoing strategy and method to engage local organizations to develop or provide cultural-competency training and collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery and its operation; and a description of how Cultural Competence is and will continue to be linked to health outcomes.
Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multilingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations.
Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility.

Sec. 5.10.3. Contractor will provide Cultural Competence requirements at orientation, training sessions, and updates as needed. Contractor, upon request of Provider, shall agree to allow Provider to certify compliance with this provision if completed through another Contractor in the Medicaid program.

[34] IL Model Contract. Sec. 2.7.4 Providers. Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multilingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations.

[35] IL Model Contract. 3.1.3 Family Planning and reproductive healthcare. 3.1.3.13 maternity care… Contractor must refer all pregnant Enrollees to the Women, Infants, and Children's (WIC) Supplemental Nutrition Program and have or be linked to case management services for identified high-risk Enrollees. Contractor must demonstrate ability to provide equally high-quality obstetrical care to special populations such as adolescents, homeless women, and women with developmental or intellectual disabilities.

[36] IL Model Contract. Sec. 5.7.9 Integrated health homes. Contractor must adhere to and implement all aspects of the IHH program designed and approved by the Department. Where requirements of the Department's IHH program overlap with the requirements of this Contract, the IHH requirements will be prioritized.

Sec. 3.1.3.15 complex and serious medical conditions: Contractor shall provide or arrange to provide high quality care for Enrollees with complex and serious medical conditions.

5.8.9 Family Planning. Contractor shall demonstrate that its network includes sufficient Family-Planning Providers to ensure timely access to Covered Services as provided in 42 CFR §438.206.

[37] Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Member to PCP (FTE) ratio not to exceed 1500:1.

[38] Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: The Contractor shall include in its network sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.

[39] Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background. The Contractor shall communicate such policies to Subcontractors.

[40] Commonwealth of Kentucky - Master Agreement Modification. Section 29.8. Additional Network Provider Requirements: **A.** The Contractor shall attempt to enroll the following Providers in its network as follows: 1. Teaching hospitals; 2. FQHCs and rural health clinics; 3.The Kentucky Commission for Children with Special Health Care Needs; and 4.Community Mental Health Centers.

If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers. Such approval is subject to Section 4.4 "**Approval of Department**." **B.** In consideration of the role that Department for Public Health, which contracts with the local health departments, plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreement shall include, but not be limited to, the following provisions: 1. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360. 2. Provide reimbursement at rates commensurate with those provided under Medicare.

[41] COMAR 10.09.66.05.B. Adequacy of Provider Network. (1) An MCO shall develop and maintain a complete network of adult and pediatric primary care, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of benefits as required by this chapter and COMAR 10.09.67.

[42] COMAR 10.09.66.05.B. Adequacy of Provider Network. (1) An MCO shall develop and maintain a complete network of adult and pediatric primary care, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of benefits as required by this chapter and COMAR 10.09.67.

[43] COMAR 10.09.66.05. For female enrollees, if the enrollee's PCP is not a women's health specialist, the MCO shall provide direct access, without the need for a referral, to a women's health specialist within the MCO's network for covered services necessary to provide women's routine and preventive health care services.

[44] COMAR 10.09.64.05. An MCO's health care delivery system shall accommodate the cultural and ethnic diversity of the population to be served.

[45] COMAR 10.09.64.05.D. An MCO shall provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions or social services, or both, a multidisciplinary team shall be used to review and develop the plan of care for special health care needs children.

COMAR 10.09.64.10.B.2.C. AIDS Case Management Services. (1) An MCO shall ensure that an enrollee with HIV/AIDS receives case management services that: (a) Link the enrollee with the full range of available benefits; (b) Link the enrollee with any additional needed services including: (i) Mental health services, (ii) Substance abuse services, (iii) Medical services, (iv) Social services, (v) Financial services, (vi) Counseling services, (vii) Educational services, (viii) Housing services, and (ix) Other required support services.

[46] MA ACO Model Contract. Sec.2.7.C. 1:1500 Enrollees. At least 1 PCP for every 200 enrollees (Sec.2.9.C.)

[47] MA ACO Model Contract. Sec.2.9.C. The Contractor shall maintain an Obstetrician/Gynecologist-to-female Enrollee ratio of one to 500, throughout the Region, provided that, EOHHS may approve a waiver of the above ratio in accordance with federal law. Such ratio should include female Enrollees age 10 and older.

[48] MA ACO Model Contract. Sec. 2.7. The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for MCO Covered Services necessary to provide women's routine and preventive health care services.

[49] MA ACO Model Contract. Sec.2.9.C. The Contractor shall ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language in the Regions provided that such provider capacity exists throughout the Region.
[50] MA ACO Model Contract. Sec. 2.8. The Contractor shall ensure that: Multilingual Network Providers and, to the extent that such capacity exists throughout the Contractor's Regions, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations;
Network Providers and interpreters/transliterators are available for those who are Deaf or hearing-impaired, to the extent that such capacity exists throughout the Contractor's Regions; Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under the Contract;
It identifies opportunities to improve the availability of fluent staff or skilled translation services in Enrollees preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care.
[51] MassHealth Managed Care Contract. Sec. 2.7.A.k. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, Enrollees with Special Health Care Needs, including individuals with disabilities, or other special populations served by the Contractor, by, at a minimum, having the capacity to, when necessary, communicate with Enrollees in languages other than English, communicate with individuals who are deaf, hard-of-hearing, or deaf blind, and making materials and information available in Alternative Formats as specified in this Contract.
[52] MA ACO Model Contract. Sec. 2.7. Community Partners. The Contractor shall contract with Behavioral Health Community Partners (BH CPs) and Long Term Services and Supports Community Partners (LTSS CPs) as described in Sections 2.5.F and 2.5.G; The Contractor shall support relationships between Community Partners and MCO-Administered ACOs as further directed by EOHHS.
Sec.2.7.(F). The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with such SIF Program providers to provide Community Support Program (CSP) services.
(G) Community Support Program (CSP) Services for Chronically Homeless Individuals
Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP services to chronically homeless individuals, including assisting in enhancing daily living skills; providing service coordination and linkages; assisting with obtaining benefits, housing and healthcare.
[53] MN Model Contract. Sec. 6.13.1 Primary Care. (B) Adequate Resources. The MCO shall have available appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its Enrollees for covered services.
[54] MN Model Contract. Sec. 6.17 Direct Access to Obstetricians and Gynecologists. Pursuant to Minnesota Statutes, § 62Q.52, the MCO shall provide Enrollees direct access without a referral or Service Authorization to the following obstetric and gynecologic services: 1) annual preventive health examinations and any subsequent obstetric or gynecologic visits determined to be Medically Necessary by the examining obstetrician or gynecologist; 2) maternity care; and 3) evaluation and necessary treatment for acute gynecologic conditions or emergencies. Direct access shall apply to obstetric and gynecologic Providers within the Enrollee's network or care system, including any Providers with whom the MCO has established referral patterns.
[55] MN Model Contract. Sec. 6.15. Serving Minority and Special Needs Populations. (E) Cultural and Racial Minorities. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various cultural and racial minority groups.
Sec. 6.23 Access to Culturally and Linguistically Competent Providers. To the extent possible, the MCO shall provide Enrollees with access to Providers who are culturally and linguistically competent in the language and culture of the Enrollee. For the purpose of this Contract, cultural and linguistic competence includes Providers who serve Enrollees who are deaf and use sign language or an alternative mode of communication. (A) Providers. The MCO agrees to work towards increasing the Provider pool of culturally and linguistically competent Providers where there is an identified need, including but not limited to, participating in STATE efforts to increase the Provider pool of culturally and linguistically competent Providers, and participating in the STATE's needs assessment process and related planning effort to expand the pool.
[56] MN Model Contract. Sec. 6.15. Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article. (D) Enrollees with Language Barriers. Services for this group include interpreter services, bilingual staff, culturally appropriate assessment and treatment. (1) When an individual is enrolled in PMAP, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language she or he speaks. (2) Upon receipt of enrollment information indicating interpreter services are needed, the MCO shall contact the Enrollee by phone or mail in the appropriate language to inform the Enrollee how to obtain Primary Care services. (3) In addition, whenever an Enrollee requests an interpreter in order to obtain services under this Contract the MCO must provide the Enrollee with access to an interpreter in accordance with section 6.1.21 of this Contract.
[57] MN Model Contract. Sec. 6.15. Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article.
(B) Persons with a Physical Disability or Chronic Illness. Services for this group include in-home services and neurological assessments.
(F)Persons with a Developmental Disability (DD). Services for this group include specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance services that are designed to maintain or increase function and prevent further deterioration or dependency and that are coordinated with available community resources and support systems, including the Enrollee's Local Agency DD case management service Provider, families, guardians and residential care Providers. Continuity of care should be a major consideration in the treatment planning process. Referrals to specialists and sub-specialists must be made when medically indicated.

[58] MN Model Contract. Sec. 6.15 Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article. (A) Persons with Serious and Persistent Mental Illness (SPMI). Services for this group include ongoing medications review and monitoring, day treatment, and other community-based alternatives to conventional therapy, and coordination with the Enrollee's case management service Provider to assure appropriate utilization of all needed psychosocial services. (B) Persons with a Physical Disability or Chronic Illness. Services for this group include in-home services and neurological assessments. (C) Abused Children and Adults, Abusive Individuals. Services for this group include comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, or emotional). … (F) Persons with Dual MI/DD or MI/CD Diagnoses. Services for this group include comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs. 2017 Families and Children Contract [MCO Name] Page 145 (G) Lesbians, Gay Men, Bisexual and Transgender Persons. Services for this group include sensitivity to critical social and family issues unique to these Enrollees. (H) Persons with a Hearing Impairment. Services for this group include access to TDD and hearing impaired interpreter services. (I) Enrollees in Need of Gender Specific MI and/or CD Treatment. The MCO must provide its Enrollees with an opportunity to receive mental health and/or chemical dependency services from a same-sex therapist and the option of participating in an all male or all-female group therapy program. (J) Children and Adolescents, including Children with SED and Children involved in the Child Protection System. Services for these groups include services specific to the needs of these groups, such as day treatment, home-based mental health services, and inpatient services. The services which the MCO delivers must be: 1) provided in the least restrictive setting; 2) individualized to meet the specific needs of each child; and 3) designed to provide early identification and treatment of mental illness. The MCO must coordinate services with the Child's Local Agency case management service Provider(s), children's mental health collaborative service coordination and family services collaborative service coordination, and must arrange for participation in the Child's wraparound services planning, upon request. … (L) **American Indians**. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various tribes

[59] MO RFP. Sec. 2.4 Health Plan Provider Networks: 2.4.1 General: a. The health plan shall establish and maintain health plan provider networks in geographically accessible locations, in accordance with the travel distance standards specified herein. The health plan's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, mental health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein. In order to maintain geographically accessible locations for members, the health plan shall look to providers in contiguous and other counties for full development of the network.

[60] MO RFP. Sec. 2.4.7 Physician Specialists: The health plan shall employ or contract with physician specialists in sufficient numbers to ensure specialty services are available in accordance with travel distance and appointment standards described herein. The health plan shall have protocols for coordinating care between primary care providers and specialists. These protocols shall include the expected response time for consults between primary care providers and specialists.

[61] MO RFP Sec. 2.4.15 School Based Dental Services: The health plan shall contract with and reimburse any licensed dental provider who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting. The health plan shall ensure that dental providers who participate in the health plan's provider network are qualified under the credentialing criteria of the health plan and are willing to accept the health plan's operating terms, including but not limited to, the health plan's fee schedule, covered expenses, and quality standards. Nothing shall prevent the health plan from instituting reasonable credentialing criteria for school-based dental services or establishing other reasonable measures designed to maintain quality of care or control costs.

[62] MO RFP. Sec. 2.3. The health plan shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. The health plan shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations.

[63] MO RFP. Sec. 2.1.7. c. Local Community Care Coordination Program (LCCCP). All LCCCPs shall incorporate the following principles: Every member has a selected primary care provider; Care is provided by a physician-directed team that collectively cares for the member; Care is coordinated and/or integrated across all aspects of health care; Member Care Management Services to include but not limited to: Comprehensive care management applying clinical knowledge to the member's condition; Care coordination; Health promotion services; Comprehensive transitional care; Individual and family support activities; Disease management; and Referrals to community and social supports are performed at the local level by the LCCCP.

[64] NJ Model Contract. Sec 4.8.8. 1 PCP:2000 enrollees per Contractor. If the Contractor includes Certified Nurse Midwives in its provider network as PCPs, it shall utilize the following ratios for CNMs as PCPs. a. 1 FTE CNM per 1000 enrollees per Contractor; 1 FTE CNM per 1500 enrollees across all Contractors. b. A minimum of two (2) providers shall be initially available for selection at the enrollee's option. Additional providers shall be included as capacity limits are needed. If the Contractor includes CNPs/CNSs in the provider network as PCPs, it shall utilize the following ratios. a. 1 FTE CNP or 1 CNS per 1000 enrollees per Contractor; 1 FTE CNP or 1 FTE CNS per 1500 enrollees cumulative across all Contractors. b. A minimum of two (2) providers where available shall be initially available for selection at the enrollee's option. Additional providers shall be included as capacity limits are reached.

[65] NJ Model Contract. Sec. 4.8.8. Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 CNPs/CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS.

[66] NJ Model Contract. Sec. 4.8.7. The Contractor shall provide access to pediatric medical subspecialists, pediatric surgical specialists, and consultants. Access to these services shall be provided when referred by a pediatrician.

[67] NJ Model Contract. Sec 4.8.8. 1 FTE primary care dentist per 2000 enrollees per Contractor; 1 FTE primary care dentist per 3500 enrollees, cumulative across all Contractors.

[68] N.J.A.C. 11:24–6.2. The HMO shall demonstrate that the projected PCP network is sufficient to meet adult, pediatric and primary ob/gyn needs of the projected enrollment on the basis of the following assumptions: i. Four primary care visits per year per member, averaging one hour per year per member; and ii. Four patient visits per hour, per PCP.

[69] NJ Model Contract. Sec 4.2.3. The Contractor shall provide female enrollees with direct access to a woman's health specialist within its network for covered care necessary to provide women's routine and preventive health care services. This shall be in addition to the enrollee's designated PCP if that PCP is not a women's health specialist.
[70] NJ Model Contract. Sec. 4.8.7. The Contractor shall include in its provider network Centers of Excellence for children with special health care needs as well as other specialty providers.
[71] NJ Model Contract. Sec. 5.14 CULTURAL AND LINGUISTIC NEEDS. The Contractor shall address the relationship between culture, language, and health care outcomes through, at a minimum, the following Cultural and Linguistic Service requirements. A. Physical and Communication Access. The Contractor shall provide documentation regarding the availability of and access procedures for services which ensure physical and communication access to: providers and any Contractor related services (e.g. office visits, health fairs); customer service or physician office telephone assistance; and, interpreter, TDD/TT services for individuals who require them in order to communicate. Document availability of interpreter, TDD/TT services. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. B. Twenty-four (24)-Hour Interpreter Access. The Contractor shall provide twenty-four (24)-hour access to oral interpreter services free of charge for all enrollees/potential enrollees including the deaf or hard of hearing at provider sites within the Contractor's network, either through telephone language services or in-person interpreters to ensure that enrollees are able to communicate with the Contractor and providers and receive covered benefits. The Contractor shall identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical). The Contractor shall provide professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family Member or friend as interpreter is inappropriate. Family Members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. The Contractor shall provide for training of its health care providers on the utilization of interpreters. C. Interpreter Listing. Throughout the term of this contract, the Contractor shall maintain a current list of interpreter agencies/oral interpreters who are "on call" to provide interpreter services free of charge to each enrollee and potential enrollee.. D. Language Threshold. In addition to interpreter services, the Contractor will provide other linguistic services to a population of enrollees if they exceed five (5) percent of those enrolled in the Contractor's Medicaid/NJ FamilyCare line of business or two hundred (200) enrollees in the Contractor's plan, whichever is greater. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. E. The Contractor shall provide the following services to the enrollee groups identified in D above. 1. Key Points of Contact a. Medical/Dental: Advice and urgent care telephone, face to face encounters with providers b. Non-medical: Enrollee assistance, orientations, and appointments 2. Types of Services a. Translated signage b. Translated written materials c. Referrals to culturally and linguistically appropriate community services programs d. Oral interpretation services available free of charge to each enrollee and potential enrollee. F. Community Advisory Committee. Contractor shall implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers (with representatives of each Medicaid/NJ FamilyCare eligibility category- See Article 5.2), community advocates, and traditional and safety net providers. The Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency. G. Group Needs Assessment. Contractor shall assess the linguistic and cultural needs of its enrollees who speak a primary language other than English. The findings of the assessment shall be submitted to DMAHS in the form of a plan entitled, "Cultural and Linguistic Services Plan" at the end of year one of the contract. In the plan, the Contractor will summarize the methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The Contractor shall ensure implementation of the plan within six months after the beginning of year two of the contract. The Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. The DMAHS approval of the plan is required prior to its implementation. H. Policies and Procedures. The Contractor shall address the special health care needs of all enrollees. The Contractor shall incorporate in its policies and procedures the values of (1) honoring enrollees' beliefs, (2) being sensitive to cultural diversity, and (3) fostering respect for enrollees' cultural backgrounds. The Contractor shall have specific policy statements on these topics and communicate them to providers and subcontractors. I. Mainstreaming. The Contractor shall be responsible for ensuring that its network providers do not intentionally segregate DMAHS enrollees from other persons receiving services. Examples of prohibited practices, based on race, color, creed, religion, sex, age, national origin, ancestry, marital status, sexual preference, income status, program membership or physical or mental disability, include, but may not be limited to, the following: 1. Denying or not providing to an enrollee any covered service or access to a facility. 2. Providing to an enrollee a similar covered service in a different manner or at a different time from that provided to other enrollees, other public or private patients or the public at large. 3. Subjecting an enrollee to segregation or separate treatment in any manner related to the receipt of any covered service. 4. Assigning times or places for the provision of services. 5. Closing a provider panel to DMAHS beneficiaries but not to other patients. J. Resolution of Cultural Issues. The Contractor shall investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State staff, providers, advocate organizations, and enrollees.
Sec 4.8.1 The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs.
Sec. 5.9.1.C. PCP Assignment. If the Contractor has not received an enrollee's PCP selection within ten (10) calendar days from the enrollee's effective date of coverage or the selected PCP's panel is closed, the Contractor shall assign a PCP and deliver an ID card by the fifteenth (15th) calendar day after the effective date of enrollment. The assignment shall be made according to the following criteria, in hierarchical order: 1. The enrollee shall be assigned to his/her current provider, if known, as long as that provider is a part of the Contractor's provider network. 2. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, as defined in Article 4.8.8. If the language and/or cultural needs of the enrollee are known to the Contractor, the enrollee shall be assigned to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts.
6.3 PROVIDER EDUCATION AND TRAINING. A. Initial Training. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and 7/2017 Accepted Article 6 – Page 3 information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants. Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups. Listed below are some examples of topics for training: 8. Cultural sensitivity to providing health care to various ethnic groups.

[72] NJ Model Contract. Sec 4.8.1 The Contractor shall ensure that its provider network includes, at a minimum: Providers who can accommodate the different languages of the enrollees including bilingual capability for any language which is the primary language of five (5) percent or more of the enrolled DMAHS population.
[73] NJ Model Contract. Sec 4.8..1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home.
[74] NJ Model Contract. Sec 4.3. The Contractor shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social service organizations, consumer organizations, and civic/community groups.
[75] NJ Model Contract. Sec. 4.8.1. H. Requirement to contract with Children's Hospital of New Jersey at Newark Beth Israel Medical Center for school-based health services. The Contractor shall contract with the Children's hospital of new Jersey at Newark Beth Israel Medical Center for the provision of primary health care services, including but not limited to, EPSDT services, and dental care services, to be provided at designated schools in the city of Newark. Providers at the school-based clinics shall meet the Contractor's credentialing and program requirements of this contract
Sec. 4.8.L. Enrollees with Special Needs. The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs. 1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home. 2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs.
Sec. 4.3. The Contractor shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social service organizations, consumer organizations, and civic/community groups.
[76] OH Model Contract. Appendix H.4. 1:2000 enrollees.
[77] OH Model Contract. Appendix H.4. In addition to the PCP capacity requirement, MCPs must also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP capacity requirement.
[78] OH Model Contract Appendix H. Although there are currently no capacity requirements of the non-PCP required provider types, MCPs are required to ensure that adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, MCPs must ensure that these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODM specified county within the region or anywhere within the region if no particular county is specified).
[79] OH Model Contract Appendix H. Although there are currently no capacity requirements of the non-PCP required provider types, MCPs are required to ensure that adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, MCPs must ensure that these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODM specified county within the region or anywhere within the region if no particular county is specified).
[80] OH Model Contract. Appendix H.4. Dental Care Providers. MCPs must contract with at least the minimum number of dentists.
[81] OH Model Contract. Appendix H.4. OB/GYNs. MCPs must contract with at least the minimum number of OB/GYNs for each county/region, all of whom must maintain a full-time obstetrical practice at a site(s) located in the specified county/region. Only MCP-contracting OB/GYNs with current hospital privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.
[82] OH Model Contract. Appendix C. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as defined by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://www.thinkculturalhealth.hhs.gov/clas), to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.
[83] PA Model Contract, Exhibit AAA(1). The Pennsylvania Health MCO (PH-MCO) must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity. (a) PCPs. Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. (b) Pediatricians as PCPs. Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).
[84] PA Model Contract, Exhibit AAA(1). c. Specialists i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural): General Surgery Cardiology Obstetrics & Gynecology Pharmacy Oncology Orthopedic Surgery Physical Therapy General Dentistry Radiology. ii. For the following provider types, the PH-MCO

must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone: Oral Surgery Urology Nursing Facility Neurology Dermatology Otolaryngology. iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

[85] PA Model Contract, Exhibit All MCOs. II. Community Based Care Management (CBCM) Program Requirements. F. The PH-MCO will be required to implement a public health dental hygiene practitioner (PHDHP) program or a dental hygienist program under the direct supervision of a dentist using CBCM funding. The hygienists must spend the majority of their time performing direct patient preventive care.

[86] PA Model Contract Exhibit AAA(3), Sec. 1.c. Specialists i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural): Obstetrics & Gynecology.

[87] PA Model Contract. Sec. V.A.6. Self-Referral/Direct Access. The PH-MCO must permit Members to select a Network Provider, including nurse midwives, to obtain maternity and gynecological care without prior approval from a PCP. This includes selecting a Network Provider to provide an annual well-woman gynecological visit, primary and preventive gynecology care, including a PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care.

PA Model Contract Sec. 3.2.4.2 Access to Services. Bidder will allow women direct access to a women's health care specialist within the Bidder's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services.

[88] PA Model Contract. Sec. V. S. 3. Opioid Use Disorder Centers of Excellence (OUD-COE). The Department will implement twenty OUD-COEs in the Physical Health Program throughout the Commonwealth. This initiative will increase the capacity to care for those seeking treatment for OUD, as well as increase the overall quality of care. The PH-MCO must comply with the Department's OUD-COE requirements specified in Exhibit G Opioid Use Disorder Centers of Excellence.

[89] PA Model Contract. V.S.2. 2. Cultural Competency Both the PH-MCO and Network Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Member cannot be permitted to present barriers to accessing and receiving quality health care; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the Member's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Member; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Member of a particular culture than to another of a differing culture.

[90] PA Model Contract. Sec. V.F.4. Limited English Proficiency (LEP) Requirements. During the Enrollment Process, the PH-MCO and/or the Department's Enrollment Specialists must seek to identify Members who speak a language other than English as their first language. Upon a Member's request, the PH-MCO must provide, at no cost to Members, oral interpretation services in the requested language or sign language interpreter services to meet the needs of the Members. These services must also include all services dictated by federal requirements for translation services designated to the PH-MCO providers if the provider is unable or unwilling to provide these services.

[91] PA Model Contract. Sec. V.A.16. Waiver Services/State Plan Amendments. a. HIV/AIDS Targeted Case Management (TCM) Program. The PH-MCO must provide for TCM services for persons with AIDS or symptomatic HIV, including access to needed medical and social services using the existing TCM program standards of practice followed by the Department or comparable standards approved by the Department. In addition, individuals within the PH-MCO who provide the TCM services must meet the same qualifications as those under the Department's TCM Program.

[92] RI RFP. Sec. 3.2.4.1 Provider Network. The Bidder maintains a robust multi-disciplinary provider network (1) to provide members with the full range of covered services; (2) that maintains providers in sufficient number, mix and geographic area; and (3) makes available all services in a timely manner.

The Bidder agrees to establish and maintain a network that is supported by written agreements that meet both State and Federal requirements and can sufficiently demonstrate to EOHHS' satisfaction the Bidder's ability to provide covered services under this Agreement. Members must have access to services that are at least equal to, or better than community norms.

[93] RI RFP. Sec. 6.1.6. Provide female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist.

[94] RI RFP. Sec. 3.2.4. In establishing and maintaining the network, the Bidder considers the following: "Cultural Competency" of providers and office staff. "Cultural Competency" is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.

RI RFP. 4.10.1. The Bidder will describe how it meets the requirements to provide multi-lingual, culturally competent and disability-centric member services: Staffs a Member Services function that is operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday); Maintain a toll-free Member Services telephone number that is staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and on weekends; Ensure TYY/TDD services and foreign language interpretation are available when needed by a Member who calls the Member Services telephone number; Notify members in writing at least once annually of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, State's and the health plan's grievance and appeals processes, after hour and emergency coverage, requirement for prior authorization of services, referrals for specialty car; Bidder should provide evidence (e.g., staff training and monitoring, policies and procedures, and any other processes) of active efforts to promote cultural competence to ensure that services are provided in a culturally competent manner to all Members including (1) giving the concerns of Members related to their racial and ethnic minority status full attention beginning with the first contact with a Member, continuing throughout the care process, and extending to evaluation of care; (2) making interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for Members with hearing impairments and the use of Braille for Members with vision impairments; and

(3) as appropriate, adopting cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its Member population. Bidder should provide evidence (e.g. staff training and monitoring, Policies and Procedures, other) of active efforts to promote cultural competence.
Sec. 3.2.7.1 Member Services. As part of the Member Services function, the Bidder has an ongoing program of member education that takes into account the multi-lingual, multi-cultural nature of the population including any members with limited English proficiency (LEP). In addition, the Bidder's Member Services function should address how the Health Plan will meet the needs of any members with low literacy skills or any members who have disabilities, including but not limited to deafness, being hard of hearing (HOH), or visual impairments. The Bidder staffs a Member Services function that is operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday). The Bidder maintains a toll-free Member Services telephone number that is staffed during regular business hours as defined above. Once a year, the Bidder notifies members in writing of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, EOHHS's and the health plan's grievance and appeals processes, after hour and emergency coverage, requirement for prior authorization of services, referrals for specialty care, and other information as identified herein. Contractor must ensure that services are provided in a culturally competent manner to all Members. Specifically, Contractor (1) must give the concerns of Members related to their racial and ethnic minority status full attention beginning with the first contact with a Member continuing throughout the care process, and extending to evaluation of care; (2) must make interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for Members with hearing impairments and the use of Braille for Members with vision impairments; and (3) as appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its Member population; (4) develop policies and procedures for the provision of language assistance services, which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats.

[95] RI RFP. Sec. 3.2.4. In establishing and maintaining the network, the Bidder considers the following: "Disability competency" of providers and the physical accessibility of their offices as it relates to the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their knowledge, experience and expertise providing services to children with disabilities.

[96] RI RFP. Sec. 4.9.1.6 Coordination with Out-of-Plan Health/Social Services, Social Determinants of Health and Housing Stabilization. EOHHS supports various special service programs targeted to persons who may be covered by RIte Care or Rhody Health Partners. The Bidder is not obligated to provide or pay for any non-plan, non-capitated services. However, these services can be essential to overall health and well-being and to assuring optimum outcome of clinical services. Bidder should help to ensure Member awareness of these services and, as appropriate develop policies and procedures to guide coordination of its in-plan and other service delivery with services delivered outside of the Health Plan. EOHHS expects that Bidder Care Plans and Care Management will promote and coordinate such services to promote best outcomes.

- Multiple services are available through programs sponsored by BHDDH, DCYF, DOH, DHS, Special Education, and others. Bidder should describe its plan for ensuring successful referrals and collaboration of out-of-plan services and other locally based social services that help people address the social determinants of poor health (e.g. a need for stable access to food, treatment for chemical dependency).
- Bidder should describe its plan to identify the manner that social determinants inform its care management strategy and how care plans incorporate strategies to mitigate the impact of social determinants of health. This should include, for example, issues related to housing stabilization and services for adults returning to the community upon release from the Department of Corrections.
- EOHHS supports a housing stabilization program that provides sheltering to those for whom homelessness is unavoidable, and rapidly re-houses the homeless in stable, permanent housing. The Bidder shall describe its policies and procedures for identifying and connecting at-risk members with physical health, behavioral health, and other social support needs to the housing stabilization program. As appropriate, the Bidder should also describe its plan for ensuring coordination between its efforts and those of its subcontractors (including but not limited to Accountable Entities (AEs), Cedar Family Centers, Integrated Health Homes (IHHs), Community Mental Health Centers (CMHCs), Patient Centered Medical Homes (PCMHs), and the health plan's behavioral health subcontractor.

[97] RI RFP. Sec. 3.2.4. The Bidder includes in its network the traditional providers of health care services for RI Medicaid population. These providers include but are not limited to FQHC/RHCs, hospital and school based clinics, Community Mental Health Centers, Home Based Therapeutic Service, as well as private practice practitioners and multi-specialty providers to meet the diverse needs of the population.

[98] SC July 2016 Contract. Sec. 6.2. CONTRACTOR Provider Network The CONTRACTOR shall establish and maintain, through written agreements, an appropriate Provider Network necessary for the provision of the services under this Contract. This includes, but is not limited to Primary Care Providers (PCPs), Specialty Providers, Hospitals and other Health Care Service Providers as identified by the Department. For geographic areas lacking Providers sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area, the Department at its sole discretion may waive the distance requirement. Sec. 6.2.1. Primary Care Provider (PCP) The CONTRACTOR shall: Implement procedures to ensure that each Medicaid Managed Care Member has a person or entity, formally designated, as primarily responsible for coordinating their health care services. Ensure each Member has access to at least one PCP with an open panel. Additional guidance is contained within the managed care policy and procedure guide.

[99]SC July 2016 Contract. Sec. 6.2.2. Specialists General Requirements The CONTRACTOR shall: 6.2.2.1.1. Be required to contract with required specialists based on the standards outlined within the Managed Care Policy and Procedure Manual. 6.2.2.1.2. Ensure each Member has access to Specialists with an open panel. Additional guidance is stated within the managed care policy and procedure guide. 6.2.2.1.3. Accept the Department's instruction to include additional specialists for a specific geographic area, when necessary. 6.2.2.1.4. Make available a choice of at least two (2) required contracted specialists and/or subspecialists who are accepting new patients within the geographic area.

[100] SC July 2016 Contract. Sec. 6.1.11. Cultural Considerations The CONTRACTOR shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
Sec. 3.16.4. . Cultural Competency As required by 42 CFR §438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

[101] Sec. 15.9 External Quality Review (EQR)(I). The MCO representative shall work with the case manager to identify what Medicaid Covered Services, in conjunction with the other identified social services, are to be provided to the Medicaid MCO Member.

[102] TN Contracts (United, Amerigroup, BCBS, and Volunteer Plans) Attachment III. 1:2500 patients.
[103] TN Contracts Attachment IV. Varies from 1:15000 (General Surgery) to 1:100000 (Allergy).
The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy; Cardiology; Dermatology; Endocrinology; Otolaryngology; Gastroenterology; General Surgery; Nephrology; Neurology; Neurosurgery; Oncology/Hematology; Ophthalmology; Orthopedics; Psychiatry (adult); Psychiatry (child and adolescent); and Urology.
[104] TN Contracts. Sec. A 2.14.4.3. The CONTRACTOR shall allow female members direct access without requiring a referral to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services.
[105] TN Contracts Sec A.2.1 1.3 Specialty Service Providers. The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region.
[106] TN Contracts Sec. A.2.18.3 Cultural Competency. As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.
[107] VA 2017 RFP Sec. 4.4.5 Access to Care Standards. In accordance with 42 C.F.R. § 438.206, the Contractor shall be responsible for arranging and administering covered services to enrolled individuals and shall ensure that its delivery system shall provide available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services. Members shall be provided with a choice of a minimum of two (2) providers for each type of service, as listed in covered services chart, Attachment B, in accordance to time and distance standards. Each provider must have the capacity to serve each member within the time and distance standards specified below. Additionally, the Contractor shall ensure that its provider network meets access to timely care for services, including where the provider travels to the member's home to provide services.
[108] VA 2017 RFP Sec. 3.7 Member Outreach and Marketing. The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.
[109] VA 2017 RFP Sec. 4.5.1 Interventions to Prevent Controlled Substance Use. The Contractor shall be responsible for complying with all DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the DMAS website at: https://www.virginiamedicaidpharmacyservices.com. The Contractor shall educate providers and members about the risk factors for opioid-related harms and provide management plan strategies to mitigate risk including but not limited to benzodiazepine and opioid tapering tools, physician/patient opioid treatment agreements, and the offering of naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages or concurrent benzodiazepine use, are present.
[110] WA Model Contract. Sec. 6.1.2. On a quarterly basis, no later than the 15th of the month following the last day of the quarter, the Contractor shall provide documentation of its providers network, including the six critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.9 of this Section to all Enrollees and shall ensure sufficient choice and number of community health centers and/or private providers to allow Enrollees a choice of service systems or clinics.
[111] WA Contract Sec. 6.9. At least 2 within 10 miles or an urban location, and 1 within 25 miles of a rural location.
[112] WA Model Contract. Sec. 10.8. Contractor must provide female Enrollee's with direct access to a women's health practitioner within the Contractor's network for covered care necessary to provide women's routine and preventive health care services, including prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice.
[113] WA Model Contract. For hemophilia and other bleeding disorders (Sec. 14.4.6); as well as COE that diagnoses autism in children (Sec. 17.1.8).
[114] WA Model Contract. Sec. 10.2. Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS). At a minimum, Contractor shall: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services; Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing; Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.; Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area; Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
[115] WA Model Contract. Sec. 6.2 Service Delivery Network. In the maintenance, monitoring and reporting of its network, the Contractor must consider the following (42 C.F.R. § 438.206(b)): 6.2.7 The cultural, racial/ethnic composition and language needs of Enrollees.
[116] WA Model Contract Sec. 14.4. Contractor shall coordinate with, and refer Enrollees to health care and social services/programs as appropriate including, but not limited to: Area Agencies on Aging; BHOs for coordination of mental health services; FQHCs/RHCs; Dental Services; DOH and LHJ services, including Title V services for children with special health care needs; Juvenile Justice and Rehabilitation; Developmental Disabilities Administration; Department of Early Learning; Educational Service Districts; Support Services for families and caregivers; Foster Care program; skilled nursing facilities; tribal entities; NEMT.
[117] WV Model Contract Sec. 2.1.3 Specialty Care. The MCO must provide or arrange for necessary specialty care, including women's health services. The MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a primary care physician for routine services, if the primary care provider is not a women's health specialist. The MCO should have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

[118] WV Model Contract Sec. 2.1.2. Availability and Access Standards. The MCO must ensure that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity.
Sec. 3.7.3 Cultural Competency The MCO must encourage and foster cultural competency among its providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding, and respect for enrollee's culture and background.

[119] WV Model Contract. Sec. 5.3 Continuity and Coordination of Care. The MCO must have programs for coordination of care that include coordination of services with community and social services generally available through contracting or non-contracting providers in the area served by the MCO.
Sec. 5.6.2. External Coordination of Care. School-Health Related Services: MCOs must work with the providers of school-health related services to coordinate care. Community and Social Services: The MCO must have programs for coordination of care that include coordination of services with community and social services generally available through contracting or non-contracting providers in the area served by the MCO.