Department of Health and Hospitals
Office of Behavioral Health

Quality Improvement Strategy

May 30, 2014

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Background

In response to rising behavioral health care costs and the limited availability of home and community-based services in many geographic areas of the State, the Department of Health and Hospitals (DHH) began a complete overhaul of its behavioral health system beginning in 2009. Numerous planning meetings were held across the State to solicit stakeholder feedback in the redesign of the behavioral health system. As a result of these efforts, a comprehensive managed care system for behavioral health, known as the Louisiana Behavioral Health Partnership (LBHP), was implemented in 2012 and provides services to:

- Medicaid and non-Medicaid eligible adults with serious mental illness (SMI), substance use disorders and addictive disorders.
- Non-Medicaid eligible youth that are in the care or custody of DHH, the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), or the Department of Education (DOE).
- Medicaid-eligible adults and children who are not institutionalized.
- A special target population of children eligible for the Coordinated System of Care.

The Coordinated System of Care, a component of the LBHP, is an evidence-based approach designed to provide services and supports to children and youth, who have significant behavioral challenges or co-occurring disorders, and are in or at imminent risk of out-of-home placement. The Coordinated System of Care integrates resources from all Louisiana's child-serving agencies, including the Department of Health and Hospitals/Office of Behavioral Health, DOE, DCFS, and OJJ. The Coordinated System of Care is also overseen by a Governance Board.

The goals of the LBHP are to:

- Foster individual, youth, and family-driven behavioral health services;
- Increase access to a fuller array of evidence-based home and community-based services that promote hope, recovery, and resilience;
- Improve quality by establishing and measuring outcomes;
- Manage costs through effective utilization of state, federal, and local resources; and
- Foster reliance on natural supports that sustain individuals and families in their homes and communities.

The Office of Behavioral Health (OBH), within the DHH, is the lead agency charged with overseeing the Behavioral Health Statewide Management Organization (SMO), which operates as a Prepaid Inpatient Health Plan (PIHP) under 42 CFR 438.2 and is responsible for managing the behavioral health services provided through the LBHP.

Since the implementation of managed care, individuals have:

- 24 hour access to member services via a toll-free number;
- Reduced service fragmentation;
- A wider array of service options
- Improved care coordination; and
- Greater involvement in care decisions.

The LBHP operates under several federal authorities, including:

- 1915b waiver, which implements managed care;
- 1915b(3) waiver, which permits savings to be used to provide additional services to at-risk children eligible for Medicaid who meet the level of need requirements;
- 1915(c) waiver, which allows home and community-based services to be provided to at-risk children eligible for Medicaid; and
- 1915(i) state plan amendment, which allows home and community-based services to be provided to adults:
    - With acute stabilization needs,
    - Who have serious mental illness,
    - Who have a major mental disorder, or
    - Who previously met the above criteria and need subsequent medically necessary services for stabilization and maintenance.

Purpose of the LBHP Quality Improvement Strategy

The Quality Improvement Strategy (QIS) provides a description of the monitoring process and standards of care used to assess and improve the quality of managed care services offered by the SMO through the LBHP. The specific state and federal requirements that must be met by the SMO are included in the SMO Request for Proposals issued by OBH, the corresponding contract between OBH and the SMO, and the 1915b, 1915c, and 1915i applications.

An intended outcome of the LBHP is to foster individual, youth, and family-driven behavioral health services. OBH obtained the input of members and other stakeholders in the development of the QIS through:

- Member and provider satisfaction surveys;
- Analysis of member grievances;
- Public forums; and
- Councils comprised of member and family advocates, including the Statewide Coordinating Council, the Behavioral Health Advisory Council, and the Regional Behavioral Health Advisory Councils.

OBH will review the QIS on an annual basis and will report any significant status updates to the Centers for Medicare and Medicaid Services (CMS).

Assessing Quality and Appropriateness of Care and Services

The OBH has established an Inter-Departmental Monitoring Team (IMT), comprised of separate Youth and Adult committees, for the purpose of:

- Developing, overseeing, and monitoring the LBHP quality assurance/quality improvement initiatives and activities;
- Ensuring compliance with the 1915b waiver, 1915c waiver, and 1915i state plan amendment requirements by collecting and analyzing data and information on all delineated performance measures;

- Ensuring compliance with the SMO contract by collecting, reviewing, and analyzing data and information for assigned deliverables and performance guarantees;
- Providing oversight and monitoring of corrective action plans (CAPS);
- Providing guidance, oversight, and monitoring of performance improvement projects; and
- Implementing the QIS.

Each IMT committee meets monthly and is composed of staff from the OBH, the DHH Bureau of Health Services Financing (Medicaid), the SMO, as well as consumer representatives. In addition, the Youth committee includes membership from LBHP partnering state agencies, including the Department of Children and Family Services (DCFS), Department of Education (DOE) and the Office of Juvenile Justice (OJJ). Committee members are identified to serve based on their knowledge and experience which can include familiarity with specific populations, understanding of particular clinical needs and processes, and/or expertise in quality assurance/improvement processes. Each member is considered a subject matter expert (SME) and is expected to contribute to the group.

Each committee member is responsible for specific activities to ensure the overarching roles and responsibilities are fulfilled, which include:

- Receiving reports as assigned by IMT Coordinator
- Reviewing reports thoroughly to ensure accuracy, specifically:
    - Is the report in the correct format?
    - Is the report for the correct reporting period?
    - Are there any blank or incomplete sections?
    - Is the submission date correct?
    - Are there any obvious errors (calculations, percentages etc.)?
- Reporting any concerns with accuracy issues to the IMT Coordinator immediately
- Reviewing and analyzing data/information included in each assigned report, including:
    - Comparison to prior reports
    - Identification of any trends
    - Determination if outliers exist
    - Consideration of implications/results
- Seeking consultation from available resources if necessary (other IMT members, other subject matter experts in various departments, appropriate SMO staff)
- Completing the Review Status Report (RSR) to summarize the report
- Attending and actively participating in IMT Committee meetings
- Presenting and leading discussion on RSRs (if necessary), which may include:
    - Significant changes in trends (positive/negative/increase/decrease)
    - Outliers
    - Concerns with attainment or compliance with thresholds/benchmarks, goals, etc.
    - Consideration of need for Action Plan and/or Corrective Action Plan
    - Other areas of concern/importance
- Providing ongoing monitoring and oversight of assigned areas

Consultation and technical support may be needed by committee members to fulfill their role. Resources available to committee members include:

- Other members of the OBH Team (clinical, analytical, etc.)
- Other state agency representatives as identified by assigned IMT Committee member
- SMO subject matter experts (to be accessed through the IMT Coordinator)
- OBH Executive Management
- Others as needed

Table 1: Roles and Responsibilities of LBHP Quality Improvement Entities

Entity	Membership	Roles and Responsibilities
OBH	▪ Lead/coordinator(s) of the LBHP ▪ OBH/SMO quality management staff ▪ Other representatives from DHH, SMO and other governmental agencies (as needed)	▪ Lead agency/contract monitor responsible for overseeing the SMO ▪ Development of SMO reporting requirements ▪ Contract monitor for the External Review Organization (EQRO)
IMT Adult Committee	▪ BHSF ▪ OBH ▪ Waiver participants ▪ SMO (Management, Finance, Operations, Quality)	▪ Provide oversight and technical support ▪ Provide forum for best practice sharing ▪ Provide support and feedback for the establishment of priorities; identification, design and implementation of quality reporting and monitoring; review of findings from discovery processes; development of remediation strategies; and identification and implementation of quality improvement strategies
IMT Youth Committee	▪ BHSF ▪ OBH ▪ DCFS ▪ OJJ ▪ DOE ▪ Waiver participants ▪ SMO (Management, Finance, Operations, Quality)	
Louisiana Behavioral Health Advisory Council and Regional Behavioral Health Advisory Councils*	▪ Providers ▪ Advocates ▪ Members ▪ Parents and other family members ▪ State agency representatives ▪ SMO representatives	▪ Review quality improvement efforts ▪ Provide forum for input from key stakeholders into quality efforts and key clinical management concerns

*The Behavioral Health Councils are consulted during QIS development and when significatn content revisions are made to the QIS.

State Access Standards

This section outlines and discusses the provisions that must be met by the SMO regarding standards for access to care and services, including availability of services; assurance of adequate capacity and services; coordination and continuity of care; and coverage and authorization of services. It also addresses cultural considerations and identification of persons with special health needs.

Provider Network

The SMO must ensure there is an adequate network of appropriate providers, supported by written agreements, to provide access to all LBHP services. In establishing and maintaining the provider network, the SMO must consider the following:

- Anticipated enrollment in the LBHP;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- Number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
- Number of network providers who are not accepting new patients; and
- Geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities.

Further, the SMO is required to provide at least as much access to services as exists within the Medicaid fee-for-service program. Members must have a choice of at least two providers which offer the appropriate level of care, unless the service is highly specialized, and is usually available through only one agency in the geographic area. In addition, members have the right to change providers.

OBH monitors to assure this standard is met by reviewing and analyzing the following:

- Geographic mapping reports submitted quarterly
- System of Care Network Development Plan status report submitted quarterly
- Network Sufficiency, Network Development Plan, Network Work Plan, Provider Training Plan, Network Inventory Report, and Prescriber Sufficiency Assessment submitted initially and annually
- Prescriber Sufficiency Assessment submitted quarterly
- Grievance data submitted monthly
- Member and provider survey data submitted annually

Provide for a Second Opinion from a Qualified Health Care Professional

The SMO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network if a qualified health care professional is not available within the network, at no cost to the enrollee. The SMO must inform members and providers, including wrap-around agencies and the family support organization, of this requirement.

OBH monitors to assure this standard is met by reviewing and evaluating the following:
- Member and Provider Handbook submitted annually
- Grievance data submitted quarterly

Adequate and Timely Coverage of Services Not Available in Network

If the network is unable to provide necessary services, including specialized services, covered under the contract to a particular enrollee, the SMO must adequately and timely cover these services out of network until a network provider is available. The SMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the member is not greater than it would be if the services were furnished within the network.

OBH monitors to assure this standard is met by reviewing and evaluating the following:
- Member Handbook
- Grievance data submitted quarterly

Provider Credentialing

The SMO is required to contract with providers of behavioral health services who are appropriately licensed and/or certified, meet the State's credentialing criteria, and who agree to the standard contract provisions and wish to participate. The SMO must demonstrate that its providers are credentialed as required by 42 CFR 438.214.

OBH monitors to ensure this standard is met by reviewing and evaluating the SMO's Credentialing and Re-credentialing Policy submitted initially and annually.

Timely Access to Services

The following table summarizes State-defined appointment access standards.

Table 3: Appointment Access Standards

Appointment Type	Access Standard	Criteria
Emergent	Within 1 hour of request after request of care is initiated; life-threatening emergencies must be managed immediately.	An individual in need of an emergent appointment is at serious or extreme risk of harm, such as current suicidal ideation with expressed intentions, recent use of substances resulting in decreased inhibition of harmful behaviors, repeated episodes of violence toward self and others, or extreme compromise of ability to care for oneself leading to physical injury.
Urgent	Within 48 hours of referral	An individual in need of an urgent appointment is at moderate risk of harm, such as suicidal ideation without intent or binge use of substances resulting in potentially harmful behaviors without current evidence of such behavior. Children/youth eligible for the CSoC must at least meet the urgent appointment standard.

Routine	14 calendar days	An individual in need of a routine appointment is at minimal to low risk of harm, such as absence of current suicidal ideation or substance use without significant episodes of potentially harmful behavior.

The SMO must:

- Require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.
- Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- Make services available 24 hours a day, 7 days a week when medically necessary.
- Establish mechanisms to ensure network providers comply with timely access requirements, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.
- Develop and implement strategies to reduce risk to members and families/caretakers, including:
    - Following up with members who do not appear for appointments or adhere to service plans.
    - Following up with members who are discharged from facilities providing 24-hour levels of care within 72 hours, to ensure access to, and attendance at, ambulatory follow-up appointments.

OBH monitors to assure this standard is met by reviewing and evaluating the:

- Appointment access reports submitted quarterly
- Performance improvement project related to ambulatory follow-up submitted annually

Cultural Considerations

The SMO must participate in OBH efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. During the Medicaid eligibility application process, the applicant may voluntarily disclose his/her race, ethnicity, and primary language spoken. In accordance with the Bureau of Census reporting standards, the data collected for race/ethnicity and primary language is passed daily from the Medicaid eligibility data system to the Medicaid Management Information System (MMIS). This information is transmitted monthly to the SMO via an 834 HIPAA-compliant enrollment data file, which also includes member enrollment/disenrollment information. The SMO uses this information to:

- Provide interpretive services to assist members with accessing behavioral health services,
- Train staff on cultural competence,
- Hire cultural and linguistically competent staff, and
- Expand network services to include culturally competent providers.

The SMO must:

- Respond to individuals with limited English proficiency through the use of bilingual/multi-cultural staff or lanuage assistance services. The language line translation system must be available 24 hours per day, 7 days a week.
- Notify members, in writing, that alternative formats are available and provide information on how to access them.
- Translate all vital materials, when a language other than English is spoken by 1,000 individuals or 5% of the eligible population.
- Translate all non-vital materials when a language other than English is spoken by 3,000 individuals or 5% of the eligible population.
- Publish, distribute, and post to its website a member handbook in English, Spanish, and Vietnamese.
- Develop and maintain standards for the delivery of culturally appropriate services for Latino, African American, Native American, Vietnamese, and other minority members.

OBH monitors to assure this standard is met by:

- Verifying, both initially and annually, the Member Handbook is available in English, Spanish, and Vietnamese on the SMO's website and provides information on how members can request and access alternative formats
- Verifying all vital and non-vital generally provided materials are available in Vietnamese and Spanish both initially and annually
- Reviewing and evaluating the SMO's Cultural Competency Plan submitted initially and annually
- Participating in the SMO's Race and Equity committee meetings

Members with Special Health Needs

Members with special health needs include:

- Children and youth under age 22, who have significant behavioral health challenges or co-occurring disorders and are in or at-risk of out-of-home placement,
- Children with behavioral health needs, who are in contact with OJJ, DCFS, or DOE,
- Adults eligible for the 1915i state plan amendment services, and
- Any individual who is an intravenous drug user, pregnant substance user, or substance using woman with dependent children or who has a dual diagnosis.

The SMO is required to:

- Screen all members to identify members with special health needs.
- Produce a treatment plan for members determined to need a course of treatment or regular care monitoring. For CSoC members, the treatment planning is performed by the wrap-around agencies.

OBH monitors to assure this standard is met by reviewing and evaluating:

- Treatment record review reports submitted monthly
- Plan of care performance measures submitted quarterly

Primary Care Coordination

The SMO must:

- Determine if members have a primary care physician. If the member does not, the SMO must refer the member to Bayou Health, the managed care delivery system for primary health care services operated by Medicaid.
- Document the member's primary care physician in the care management record, or if none, follow up on the primary care physician referral as part of the ongoing care management process.
- Attempt to obtain consent for release of information from the member or authorized representative to coordinate with the primary care physician and other health care professionals.
- Document the date of annual well care visits and track to assure primary care visits are scheduled and kept.
- If medications are prescribed by the SMO's providers, obtain a list of medications prescribed by the member's primary care physician and other specialists for a complete and reconciled medication list.
- Require that all network providers request a standardized release of information from each member to allow the network provider to coordinate treatment with the member's primary care physician.
- Coordinate care with the primary care physician, with the member's authorization, to promote overall health and wellness.
- Coordinate the services the SMO furnishes to the member with the services the member receives from any Bayou Health managed care organization.
- Share with other Bayou Health managed care organizations serving the member the results of its identification and assessment of any member with special health care needs to ensure services are not duplicated.
- Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR, parts 160 and 164.

OBH monitors to assure this standard is met by reviewing and evaluating primary care referral data presented quarterly at the DHH Business Review meetings.

Coverage and Authorization of Services

The SMO is responsible for the provision of all administrative and covered services to enrolled members. Different members are eligible for different service packages which must be tracked by the SMO. All behavioral health services for inpatient and outpatient hospital services with a primary behavioral health diagnosis, and behavioral health community-based services, including clinic services, are included in the SMO's contract.

The SMO must:

- Ensure the amount, duration, and scope of LBHP services are no less than the same services furnished to beneficiaries under the Medicaid fee-for-service program.

- Track the benefit package and funding source of each eligible member and ensure the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered services.
- Ensure covered services are available statewide. The CSoC waiver is expected to be implemented statewide by July 2014.
- Provide all medically necessary services, based on the State Medicaid program's definition, to members, which at a minimum cover:
    - The prevention, diagnosis, and treatment of health impairments.
    - The ability to receive age-appropriate growth and development.
    - The ability to attain, maintain, or regain functional capacity.
- Have written policies and procedures in place for processing requests for initial and continuing service authorization, including addressing instances of a provider refusing to provide a service or not requesting services in a timely manner.
- Have mechanisms in place to ensure consistent application of review criteria for authorization decisions.
- Have a mechanism in place to allow members to submit a service authorization request verbally. This process must be included in the member handbook and incorporated in the grievance and appeal procedures.
- Consult with the requesting provider when appropriate.
- Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Provide for the following decisions and notices:
    - In regards to standard authorization decisions, the SMO must provide notice as expeditiously as the member's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the member or the provider requests extension OR the SMO justifies to OBH, upon request, a need for additional information and how the extension is in the member's best interest.
    - For cases in which a provider indicates, or the SMO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the SMO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request. An extension of up to 14 additional calendar days may be given if the member or provider requests an extension OR the SMO justifies to OBH, upon request, a need for additional information and how the extension is in the member's best interest.
- Not require members to receive prior authorization for emergency services, even if the emergency service provider does not have a contract with the SMO.
- Track member's authorization period for psychiatric residential treatment and provide notification to the responsible party when a re-certification is due.
- Generate a prior authorization for each Psychiatric Rehabilitation Treatment Facility admission within 48 hours of completion of the screen.

OBH ensures this standard is met by reviewing and evaluating the SMO's:

- Prior authorization reports, which allow OBH to randomly check prior authorized plans of care for compliance with federal requirements
- Written policies and procedures for processing requests for initial and continuing authorization of services
- Member Handbook submitted initially and annually

Notice of Adverse Action

The SMO must notify the requesting provider and give the member written notice of any decision made by the SMO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested as expeditiously as the enrollee's health condition requires and within 10 days before the date of action.

The notice must explain the:

- Action the SMO has taken or intends to take,
- Reasons for the action,
- Member's, or provider acting on behalf of the member, right to file an appeal with the SMO,
- Member's right to request a State Fair Hearing, after the SMO's appeal process has been exhausted,
- Procedures for requesting an appeal,
- Circumstances under which expedited resolution is available and how to request it, and
- Member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

The SMO must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The SMO must acknowledge receipt of each grievance and appeal by sending an acknowledgement letter via the US Postal Service to the originator of the appeal or grievance within three business days.

If the member appeals, the SMO must: provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing; provide the member and his or her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents and records considered during the appeals process; and include as parties to the appeal, the member and his or her representative and the legal representative of a deceased member's estate.

The SMO must ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision and if deciding any appeals of a denial based on lack of medical necessity or regarding a denial of expedited resolution, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease.

The SMO must not create barriers to timely due process. Examples of creating barriers include, but are not limited to:

- Including binding arbitration clauses in member choice forms
- Labeling grievances as inquiries or complaints and funneling into an informal review
- Failing to inform members of their due process rights
- Failing to log and process grievances and appeals
- Failing to issue a proper notice, including vague or illegible notices
- Failing to inform of continuation of benefits
- Failing to inform of right to State Fair Hearing

OBH monitors to assure this standard is met by reviewing and evaluating:

- The SMO's Appeals Process policy submitted initially and annually
- Appeal and grievance data submitted quarterly

Compensation for Utilization Management Activities

Utilization management is the component of care management that evaluates the medical necessity of health care services according to established criteria and practice guidelines to ensure the right amount of services are provided when the member needs them. Utilization management focuses on individual and system outliers that require review to assess if individual members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services.

The SMO must:

- Implement a utilization management program that has a sufficient number of Licensed Mental Health Professionals, including licensed addiction counselors, a board-certified psychiatrist, and a board-certified addictionologist, available 24 hours, 7 days per week.
- Ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

OBH monitors to ensure this standard is met by reviewing and evaluating the SMO's Quality Improvement Utilization Management Evaluation submitted on an annual basis.

State Structure and Operations Standards

Provider Selection

The SMO is required to have written policies and procedures for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the SMO, consistent with federal and state regulations for the selection and retention of providers, credentialing/re-credentialing, and non-discrimination.

Further, the SMO is required to contract with providers of behavioral health services who are appropriately licensed and/or certified, meet Louisiana's credentialing criteria, agree to the standard

contract provisions, and who wish to participate. The SMO is not permitted to subcontract with providers excluded from participation in federal health care program pursuant to section 1128 and section 1128A of the Social Security Act.

OBH monitors to ensure this standard is met by:

- Reviewing and evaluating the SMO's Credentialing and Re-credentialing Plan both initially and annually
- Meeting with the SMO and DHH Program Integrity quarterly to discuss excluded providers and program integrity investigations of providers

Confidentiality

The SMO must abide by the laws and regulations concerning confidentially which safeguard information and the member/client confidentiality as specified in 45 CFR, parts 160 and 164.

The SMO must require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456.

OBH monitors to ensure this standard is met by reviewing and evaluating the SMO's HIPAA and Privacy Plan and policies submitted initially.

Grievance System

The SMO must have a grievance system, which complies with 42 CFR 438 Subpart F, in place for members that includes a grievance process, an appeal process, and access to the State's fair-hearing system.

Filing requirements:

- A member may file a grievance and a SMO level appeal, and may request a State Fair Hearing once the SMO's appeals process has been exhausted.
- A network provider, acting on behalf of the member and with the member's written consent, may file an appeal or grievance.
- The member must be allowed 30 calendar days from the date on the SMO's notice of action. Within that timeframe, the member or a representative acting on their behalf may file an appeal, or the provider may file an appeal on behalf of the member.

OBH monitors to ensure this standard is met by reviewing and evaluating:

- The SMO's Grievance System and Appeal System policy both initially and annually
- Appeal and grievance data on a quarterly basis

Fraud, Waste, and Abuse Detection

The SMO is required to develop and maintain internal controls to prevent and detect fraud and must immediately report any suspicion or knowledge of fraud and abuse. The SMO has established a Fraud

and Abuse unit comprised of experienced fraud and abuse reviewers who are charged with preventing, detecting, investigating, and reporting suspected fraud and abuse committed by providers, members, SMO employees, or other contracted entities.

The SMO educates employees, contractors, providers, and members about fraud and abuse and how to report it. In addition, the OBH toll-free Provider Compliance Hotline number and explanatory information about fraud, waste, and abuse is included in the member and provider handbooks.

OBH monitors to ensure this deliverable is met by:

- Reviewing the Fraud and Abuse Compliance Plan submitted initially and annually
- Reviewing financial reports submitted monthly and quarterly
- Reviewing grievance reports submitted quarterly
- Meeting with the SMO and DHH Program Integrity quarterly to discuss excluded providers and program integrity investigations of providers

State Measurement and Improvement Standards

Practice Guidelines

In accordance with federal regulations, OBH requires the SMO to adopt practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the behavioral health field,
- Consider the needs of enrollees,
- Are adopted in consultation with contracting health care professionals,
- Are reviewed and updated periodically as appropriate, and
- Are disseminated to all affected providers, and upon request to enrollees and potential enrollees.

The SMO must use practice guidelines as a basis for decisions regarding utilization management, member education, provider education, coverage of services and other areas to which practice guidelines apply. The SMO must implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the SMO must monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures. Using information acquired through quality and utilization management activities, the SMO must recommend implementation of practice guidelines within the behavioral health delivery system, including measures of compliance, fidelity and outcomes and a process to integrate practice guidelines into care management and utilization reviews to OBH at least annually.

OBH monitors to ensure this standard is met by reviewing and evaluating the SMO's practice guidelines initially and annually.

Quality Assessment and Performance Improvement Program

The SMO is required to have an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to members. At a minimum, the SMO must:

- Conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction (refer to Appendix C).
- Have mechanisms to detect over and under-utilization of services.
- Have a sufficient number of qualified quality management personnel to implement requirements specified in the contract.
- Provide a mechanism for the input and participation of members, families/caretakers, the CSoC Governance Board, OBH, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
- Report to OBH the results and findings of performance measures compared to expected results and findings, including performance improvement efforts and activities planned/taken to improve outcomes (refer to Appendix A and D).

OBH monitors to ensure this standard is met by reviewing and evaluating the SMO's:

- Performance measure data, including 1915b, 1915c, and 1915i performance measures, based on the established reporting frequency which ranges from monthly to annually
- Annual performance improvement projects
- QAPI Program Evaluation report sbubmitted annually
- Outcome Management and Quality Improvement Plan submitted initially and annually

In addition, OBH representatives participate in the SMO's QAPI committee meetings held quarterly.

External Quality Reviews

Federal regulations require states to provide for an annual external independent quality review of the quality outcomes, timeliness of, and access to services provided by Medicaid managed care organizations.

To meet this requirement, OBH contracts with an External Quality Review Organization (EQRO) to perform the following mandatory activities:

- Validation of performance improvement projects
- Validation of select performance measures
- A review to determine the SMO's compliance with federal Medicaid managed care regulations.

In addition, the EQRO will validate both the encounter data reported by the SMO and the member and provider satisfaction surveys administered by the SMO.

The EQRO will issue a technical report which will provide detailed information regarding the regulatory compliance of the SMO, as well as the results of performance improvement projects and performance

measures. The report will also identify strengths, opportunities for improvement, and recommendations, which will be utilized by OBH and the IMT Committee for the development and advancement of quality improvement activities. If the SMO is deemed non-compliant during any aspect of the external quality review process, a corrective action plan will be developed by the SMO to address the areas of non-compliance, including a timeline for achieving compliance. The IMT will monitor the corrective action plan from development through closure.

The Department will provide copies of the EQRO results and reports, upon request, to interested parties through print or electronic media or alternative formats for persons with sensory impairments. The Department will also provide copies of the EQRO results and reports to CMS.

OBH Fiscal Audit Section

The mission of the OBH Fiscal Audit Section is to examine and evaluate the effectiveness, efficiency, and economy of the Department's operations, and to report the results of the evaluations, with recommendations for improvements, to management.

It is the goal of the OBH Fiscal Audit Section to be a model auditing organization, which supplies management, technical assistance, fiscal monitoring and audit services to OBH and OBH administrative staff regarding the overall effectiveness of the operations and the accuracy and adequacy of the information designed to control those operations.

Appendix A –Waiver and State Plan Performance Measures

M = Monthly
Q = Quarterly
SA = Semi-Annually
A = Annually

	DATA ELEMENT	SAMPLE	REPORT REVIEW FREQUENCY	1915B	1915C	1915I
Access	Appointment access		Q	X		
	Client surveys indicate easy/timely access to services and providers and client/family involvement and choice in treatment planning		A	X		
	Number of persons served in evidence-based practices and promising practices that have been implemented to fidelity	100%	Q	X		
	Utilization of in-home and community services	100%	Q	X		
Assessment	Clinician ratings (e.g., Child and Adolescent Needs and Strengths (CANS) assessment show improved functioning with treatment)	Representative sample	Q	X		
	Number of children, under age six, assessed and with early intervention service plans developed	100%	SA	X		
	Youth screened, identified as at-risk and referred to wrap-around agency	100%	Q	X		
	Number and/or percent of participants who were determined to meet Level of Care requirements prior to receiving waiver services.	100%	Q		X	X
	Number and/or percent of participants who receive their annual Level of Care evaluation within twelve months of the previous Level of Care evaluation.	Representative sample	Q		X	X
	Number and/or percent of participants' initial Level of Care determination forms/instruments that were completed as required in the approved waiver.	Representative sample	Q		X	X
	Number and/or percent of Level of Care determinations made by a qualified evaluator.	Representative sample	Q		X	X
	Number and/or percent of child/youths' semi-annual level of care determinations where level of care criteria was applied correctly.	Representative sample	Q		X	
	Number and/or percent of adults' annual determinations, where level of care criteria was applied correctly.	Representative sample	SA			X
Providers	Number and/or percent of active providers (by provider type) meeting ongoing training requirements.	100%	A		X	X
	Number and/or percent of non-	100%	M		X	X

	DATA ELEMENT	SAMPLE	REPORT REVIEW FREQUENCY	1915B	1915C	1915I
	licensed/non-certified providers of waiver services that meet training requirements					
	Number and/or percent of provider trainings operated by SMO.	100%	Q		X	X
	Number and/or percent of providers providing waiver services that have an active agreement with the SMO.	100%	Q		X	X
	Number and/or percent of Waiver providers providing waiver services continuously meeting licensure, training, and certification requirements while furnishing waiver services.	100%	Q		X	X
Plan of Care	Number and/or percent of participant records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.	Representative sample	Q		X	X
	Number and/or percent of participant records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.	Representative sample	Q		X	X
	Number and/or percent of participant reviewed who had plans of care that were adequate and appropriate to their needs and goals (including health care needs) as indicated in the assessment(s).	Representative sample	Q		X	X
	Number and/or percent of plans of care that address participants goals as indicated in the assessment(s)	Representative sample	Q		X	X
	Number and/or percent of child/youths' plans of care that include the participant's and/or parent's/caregiver's signature as specified in the approved waiver.	Representative sample	Q		X	
	Number and/or percent of child/youths' plans of care that were developed by a Child and Family Team.	Representative sample	Q		X	
	Number and/or percent of participants' plans of care that were developed by and interdisciplinary team.	Representative sample	Q			X
	Proportion of children/youths reporting their wraparound facilitator helps them to know what waiver services are available	Representative sample	Q		X	
	Proportion of participants reporting their care coordinator helps them to know what waiver services are available	Representative sample	Q			X
	Client surveys indicate client/family involvement and choice in treatment planning		A	X		
	Number of wrap-around plans developed per youth served	100%	Q	X		
	Number and/or percent of participants	100%	Q		X	X

	DATA ELEMENT	SAMPLE	REPORT REVIEW FREQUENCY	1915B	1915C	1915I
	whose plans of care were updated within 90 days of the last update.					
	Number and/or percent of participants whose plans of care were updated when warranted by changes in their needs	100%	A		X	X
	Number and/or percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care	Representative sample	Q		X	X
	Proportion of new waiver participants who are receiving services according to their PCP within 45 days of PCP approval.	Representative sample	Q		X	X
	Utilization of family and peer support services	100%	Q	X		
	Utilization of natural supports and claims paid services	100%	Q	X		
	Number of peer specialists engaged in service to clients served		Q	X		
Health and Welfare	Number and/or percent of participants who received information regarding their rights to a State Fair Hearing via the Notice of Action form.	Representative sample	A		X	X
	Number and/or percent of grievances filed by participants that were resolved within 14 calendar days according to approved waiver guidelines.	100%	Q		X	X
	Incidents and restrictive interventions	100%	Q	X		
	Number and/or percent of reports related to the abuse, neglect, or exploitation of participants where an investigation was initiated within established time frames.	100%	Q		X	X
	Number and/or percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of children.	100%	Q		X	X
	Number and/or percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated.	100%	Q		X	X
	Standardized consumer and family self-report surveys demonstrating improved functioning, reduced symptom severity and improved quality of life		A	X		
	Satisfaction survey with reports of clients/caretakers perception of the quality, outcomes, involvement in and coordination of services provided		A	X		
	Crisis plans developed and implemented as part of individual service plan	Representative sample	Q	X		
	Juvenile justice involvement	100%	Q	X	X	
	School attendance	100%	Q	X	X	
	School conduct	100%	Q	X	X	

	DATA ELEMENT	SAMPLE	REPORT REVIEW FREQUENCY	1915B	1915C	1915I
	School performance	100%	Q	X	X	
	Number or children placed in alternative school placement	100%	Q	X	X	
	Numbers of children being placed in more restrictive or out-of-home settings	100%	Q	X	X	
	Community tenure for those served, who are at risk for psychiatric re-hospitalization	100%	Q	X		
	Number of inpatient admissions and average length of stay by diagnostic group		Q	X		
	Average length of stay, by diagnostic group, for intermediate inpatient care		Q	X		
	Crisis services utilization	100%	Q	X		
	Number of persons served in EBPs and promising practices that have been implemented to fidelity	100%	Q	X		
	Emergency department utilization	100%	Q	X		
	Follow up after discharge from inpatient mental health (MH) facility	100%	Q	X		
	Follow up after discharge from inpatient substance abuse (SA) facility		Q	X		
	Readmission to substance abuse facility	100%	Q	X		
	Number of readmissions to mental health inpatient facility	100%	Q	X		
	Drug utilization review and identification of behavioral health needs		Q	X		
	Authenticate pharmacy data for high risk population		Q	X		
Financial	Denied claims		Q	X		
	Number and/or percent of claims verified through the SMO's compliance audit to have paid in accordance with the participant's service plan.	Representative sample	Q		X	X
	Number and/or percent of providers that have payment recouped for waiver services provided without supporting documentation.	Representative sample	Q			X
	Cost per person, served per month		Q	X		

MEASURE	STANDARD
Claims administration	
Financial payment (dollar) accuracy – 97% of audited claim dollars paid accurately - Percentage of audited claim dollars paid accurately. - Calculated as the total audited "paid" dollars minus the absolute value of over-and/or under- payments, divided by the total audited paid dollars. - Measurement using monthly system-generated reports.	97%
Procedural accuracy - 99% of audited claims processed without procedural error; - Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. - Measurement using monthly system generated reports.	99%
Turn-around-time (TAT) – 95% of clean claims paid to all providers within 30 days. Claim means 1) a bill for services; 2) a line item of services or 3) all services for one recipient within a bill - "Clean claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the DHH or SMO's claim system. It does not include a claim from a provider who is under investigation for fraud and abuse or a claim under review for medical necessity. - Measurement is percent paid within time frame specified using monthly system-generated reports. - The date receipt is the date the SMO receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.	95%
TAT – 99% of all provider claims paid within 45 days - "Clean claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the DHH or SMO's claim system. It does not include a claim from a provider who is under investigation for fraud and abuse or a claim under review for medical necessity. - Measurement is percent paid within time frame specified using monthly system-generated reports.	99%
Telephone responsiveness	
Call Abandonment Rate - Member/ Provider Services Line(s) less than 3 percent - Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. - Measured using monthly system-generated reports.	≤5%
Average Speed to Answer (ASA) – Member/Provider Services Line(s) all calls answered within 30 seconds - Measured using monthly system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.	30 seconds
Clinical	
Ambulatory follow up within 7 days of discharge from 24-hour facility - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported quarterly as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass
Ambulatory follow up within 30 days of discharge from 24-hour facility - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported quarterly as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent

	version of NCQA Quality Compass
Readmission Rate – less than 12 percent of Members readmitted within 30 days to same acute level of care - Measurement using system-generated reports. - Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance abuse diagnosis.	< 12%
Percent of adult high service users (two or more IP admissions or four ER visits in a year) enrolled in an assertive community treatment program or psychosocial rehab.	> 90%
Satisfaction	
Annual Member Satisfaction Survey: 90% positive response rate - Members shall rate "satisfied" or better on the annual Member satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options. - Survey domains to include client/family involvement and choice in treatment planning. - The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor.	≥83%
Annual Provider Satisfaction Survey: 85% positive response rate - Providers shall rate "satisfied" or better on the annual Provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options. - The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor.	≥80%
Account Management	
Timely completion of Implementation or Annual Plan Milestones: - Compliance measured as the number of milestones satisfactorily completed according to DHH by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. - SMO to provide specific plans for review and approval by DHH. - Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. - Milestones missed due to factors beyond SMO's control will not be counted in measurement.	90%

Appendix C – Performance Improvement Projects

Category	Topic	Rationale	Contract Year
Non-Clinical	Improve Member Access to Emergent, Urgent, and Routine Appointments	Avoiding delays in care is essential to prevent further deterioration of a member's condition.	Year 1 and 2
Non-Clinical	Ambulatory Follow-Up After Hospitalization for Mental Illness	Ambulatory follow-up after inpatient treatment is an important component of care management and ensures that any recovery or stabilization that occurred during hospitalization is maintained and that further gains continue in the least restrictive environment possible.	Year 1, 2, and 3
Clinical	Improve the Number of CSoC Treatment Plans (Plans of Care) with Service Authorization at First Review	Appropriate referrals to community-based services at the time that the plan of care is developed helps decrease the risk of future out-of-home placement.	Year 1 and 2

Appendix D – RFP/Contract Deliverables

SMO Deliverable	Frequency
Claims accuracy report	Monthly
Client Level Data File	Monthly
CSoC Utilization and Cost Data Report	Monthly
Corporate Compliance Handbook	
Credentialing and Re-credentialing Program Description Policy	Annually
Cultural Competency Plan	Annually
Encounter data file	Monthly
Financial statements	Quarterly & Annually
Fraud, Waste, and Abuse Compliance Plan	Annually
Geographic mapping report	Quarterly
Grievance and appeals report	Monthly
Grievance system and appeals process	Annually
HIPAA and Privacy Plan and Policies	Initially
Managed care days and payment to hospitals report	Annually
Medicaid Enrollment Report	Monthly
Member Handbook	Annually
Member Satisfaction Survey	Annually
Network Development Plan	Annually
Network Inventory	Annually
Network Status Report	Quarterly
Network Sufficiency Report	Quarterly & Annually
Network Work Plan	Annually
Performance Improvement Projects	Annually
Performance Guarantee Report	Monthly & Annually
Practice Guidelines report	Annually
Prescriber Sufficiency Assessment	Annually
Provider Handbook	Annually
Provider Relations Plan	Annually
Provider Termination Policy	Annually
Provider Training Plan	Annually
Quality Improvement/Utilization Management Evaluation	Annually
Quality Work Plan	Annually
Treatment Record Review	Monthly
Transition Plan	Annually