October 24, 2012

Quality Strategy for the Louisiana Behavioral Healthcare Prepaid Inpatient Healthcare Plan Waiver

Louisiana Department of Health and Hospitals, Bureau of Health Services Financing

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Quality Strategy Overview

Following the guidance of the State Legislature and the Louisiana Health Care Reform Act of 2007, the Department of Health and Hospitals (DHH) is transitioning from the current Medicaid fee-for-service (FFS) delivery system to a behavioral health coordinated system of care (CSoC) that will serve at-risk children and youth with significant behavioral health challenges or co-occurring disorders that are in, or at imminent risk of, out-of-home placement. Further, all eligible children and youth in need of behavioral health care, adults with serious and persistent mental illness (SPMI) or co-occurring disorders (COD) of mental illness and substance use, and adult substance abuse services will be managed by the statewide management organization (SMO), the State's behavioral health prepaid inpatient health plan (PIHP).

DHH has defined its mission in the waiver program as providing statewide leadership to most effectively utilize resources to promote the health and well-being of Louisianans in this SMO program. The State intends to promote and further its mission by defining measureable results that will improve Medicaid and Title XXI Children's Health Insurance Program enrolled individuals' access and satisfaction, maximize program efficiency, effectiveness and responsiveness and reduce operational and service costs.

The values of recovery, self-determination, person-centered planning and consumer- and family-driven services are the basis for this waiver program. These values are consistent with the State's system reform goals, including to:

- Increase access to a fuller array of evidence-based in-home and community services, including home- and community-based services (HCBS) under a 1915(c) waiver for children that promotes hope, recovery and resilience
- Improve quality by establishing and measuring outcomes
- Manage costs through effective utilization of State, federal and local resources

Quality Improvement Strategy Development

The Louisiana quality improvement strategy (QIS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess and continually improve the delivery of quality behavioral healthcare provided through the 1915(b)(c)(i) program, where the Children's CSoC Severely Emotionally Disturbed (SED) 1915(c) HCBS Waiver and the Adult Psychosocial Rehabilitation 1915(i) State Plan for SPMI Adults are administered through the 1915(b) Mandatory Enrollment and Selective Services Waiver, authorizing the behavioral health SMO.

The SMO contract will be effective March 1, 2012. The QIS provides a framework for the State of Louisiana (State) to communicate the vision, objectives and monitoring strategies for attaining cost effectiveness, quality and timely access. It encompasses an interdisciplinary collaborative approach through partnerships with members, stakeholders, governmental departments and offices, contractors, SMO, community groups and legislators.

The QIS supports the mission of the Louisiana DHH to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, the development of a fuller array of evidence-based in-home and community-based services and the utilization of available resources in the most effective manner.

DHH created a broad-based governance structure to ensure consumer and family participation in the governance of the program. As the agency with primary responsibility for implementation, management, reporting and monitoring of the programs under the waiver, the Office of Behavioral Health (OBH) has established the Inter-Departmental Monitoring Team (IMT) to facilitate the development and implementation of the QIS. The IMT includes representatives from the Health and Human Services, Bureau of Health Services Financing (BHSF), OBH, the Department of Children & Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). OBH, which facilitates the IMT, has the oversight responsibility for the development and implementation of the QIS. Three main sources of information guide the updates to the QIS: the external quality review (EQR) technical report; feedback from governmental agencies, the SMO, providers, consumers and advocates; and the IMT's annual review of the effectiveness of the quality plan. This combined information assists the IMT and the SMO to identify quality initiatives and metrics of importance to the Medicaid population.

The EQR annual technical report provides detailed information on the regulatory compliance of the SMO, as well as results of performance improvement projects (PIPs) and performance measures (PMs). The report provides information about the quality, timeliness and accessibility of care furnished by the SMO, assesses its strengths and weaknesses and identifies opportunities for improvement. The IMT uses this information to update the QIS and to initiate and develop quality improvement projects.

Pursuant to 42 CFR 438.310 through 438.370, the DHH contracts with an external quality review organization (EQRO) to write an annual independent EQR technical report. The following three activities are mandatory to be included in the EQR report and will be conducted by the EQRO: (1) determining SMO compliance with federal Medicaid managed care regulations, (2) validation of PMs produced by the SMO and (3) validation of PIPs undertaken by the SMO. The organization conducting the EQR uses the required Centers for Medicare & Medicaid Services (CMS) published protocols for these activities.

Medicaid member input into the development of the QIS and the annual plan is sought through a variety of methods. SMO administers a State-approved consumer satisfaction survey. The survey utilizes the sampling method and format defined by the National Committee for Quality Assurance (NCQA). The results of the survey must be submitted to OBH, as outlined in the SMO's contract under the statistical reporting requirements. Findings from the results are incorporated into the QIS. Additional sources of member input include analysis of grievances, which are reviewed for quality purposes, as well as public forums, such as State and regional advisory councils, including the Children's Statewide Coordinating Council, the State Behavioral Health Advisory Council and the Regional Behavioral Health Advisory Councils. Each advisory council includes consumers and family members to advise OBH and the SMO about the provision of services.

The IMT and SMO draft quality improvement goals and activities and integrate these into the QIS for review and feedback by key external stakeholders. OBH and the SMO submit the QIS for public comment whenever significant changes are made to the document. A newspaper notice in the State's eight (8) major daily newspapers, as well as the October Louisiana Register, was placed on September 24, 2010, notifying the public of the availability of proposed State Plan Amendments, including proposed 1915(c) and 1915(b) waivers, as well as a public meeting on September 30, 2010. The newspaper notice listed the availability of documents on the Coordinated System of Care website www.dss.la.gov/csoc, as well as the DHH website. The draft of the 2011 QIS was placed on the DHH Website, February 18, 2011 at: http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1568, indicating a 30-day period for public input. In addition, the SMO presented the 2011 QIS update for comments at a SMO Quality Assurance and Performance Improvement (QAPI) committee meeting and at their Children's Statewide Coordinating Council, the State Behavioral Health Advisory Council and the Regional Behavioral Health Advisory Council meetings in the second quarter of 2012.

Suggested revisions to the proposed quality strategy, or improvement goals, are reflected in the updated QIS. Following approval by OBH, any amendments to the quality strategy will be shared with CMS. The final QIS is also published on the OBH website. The QIS is permanently posted on the State's website at: http://new.dhh.louisiana.gov/index.cfm/page/538.

A public process, with significant opportunity for public comment by individuals of all races and ethnicities, was utilized by OBH in designing the framework for the waiver program. The planning for the system design and development work of the CSoC initiative was conducted by the CSoC planning group. The planning group was composed of key agency staff and external stakeholders, including family members, advocates and providers. In a planning group retreat, over 40 agency and stakeholder leaders agreed, as follows, on the values and principles for the Louisiana CSoC:

- Family-driven and youth-guided
- Home- and community-based
- Strength-based and individualized
- Culturally competent and linguistically competent
- Integrated across systems
- Connected to natural helping networks
- Data-driven, outcomes-oriented

Stakeholder meetings were held monthly throughout the implementation planning and CSoC start-up activities. The meetings provided all interested individuals progress reports on the CSoC planning efforts and gained feedback and input. A website was also developed, which provided information about the CSoC plan and a feedback link for public comments.

The SMO maintains open communication with consumers, providers and other stakeholders through provider satisfaction surveys, complaint tracking and analysis and activities with the advisory councils. Outreach, cultural sensitivity and coordination with community resources for the best possible consumer outcomes are the central focus of the consumer affairs and relations office. Stakeholder feedback is incorporated for program improvement through SMO's internal quality improvement program and the QIS.

Quality Improvement Strategy Implementation

The DHH has delegated quality oversight responsibility for Medicaid behavioral health waiver programs to the OBH health. OBH responsibilities include oversight and monitoring of quality plans and improvement activities through the established IMT. Through the efforts of the IMT, the QIS has a structure and processes that support and encourage achievement of sustainable improvements in the quality of care and services provided to all Medicaid participants. The quality strategy promotes integration and collaboration, both horizontally and vertically, across state agencies and externally with key stakeholders, including members, advocacy groups, providers and CMS. Specific activities of OBH include:

- Coordination of monitoring activities and receipt of required reports
- Plans/arrangements for monthly IMT meetings
- Coordination of the annual onsite review

Each organization or governmental agency represented on the IMT has its own quality and financial staff that is accountable for all phases of the quality improvement (QI) process. IMT representatives link these staff to a unifying point. The IMT is the central forum for communication and collaboration for quality strategies, plans and activities and provides the opportunity to develop systematic and integrated approaches to quality activities. The QIS employs a deliberate process of ongoing continuous quality improvement (QI), with feedback mechanisms that affect change and improve quality of care to participants. The IMT uses data and information at each stage of the QI process to analyze and identify trends, as well as sentinel and adverse events. IMT members discuss findings to identify issues and prioritize opportunities for strategically developing an overall QI work plan to ensure appropriate system of care integration of QI activities, such as PIPs and PMs. Within this process, opportunities are sought to develop collaborative quality activities.

Members of the IMT participate in a scheduled rotation of reporting quality and financial activities that are the formal processes focusing on critical, high-impact issues to determine compliance in meeting established goals. QI reporting minimally includes statistical analysis, root cause analysis, analysis of barriers and improvement interventions. Quarterly presentations at the monthly IMT meetings allow opportunity for dialogue, exchange of information and identification of best practices. As the committee process continues to develop, greater emphasis will be placed upon review, approval and evaluation of quality plans. Specifically, IMT monitoring includes the following:

- Compliance with contracts between SMO and the State
- Compliance with Medicaid waivers, including all 1915(b) monitoring activities and all HCBS performance measures (e.g., financial, administrative oversight, level of care (LOC), plan of correction (POC), etc.)
- Review of findings from other monitoring activities
- SMO corrective action plan, focusing on recommendations from independent assessment, EQRO and IMT annual review
- Service utilization measures
- Recommendations
- Technical assistance

In addition to IMT monitoring, there are monthly meetings of OBH and SMO quality management staff to work on operational details to ensure that quality activities are consistent with the State QIS and contract requirements. Quarterly report results are documented in IMT meeting minutes and communicated to stakeholders and the SMO QAPI Committee. The SMO QAPI Committee reviews State QIS activities and provides direction, feedback and support for strategic quality issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for Medicaid participants. Quality results are reported to providers through plan mailings. Members and families receive QAPI activity information through SMO member newsletters, following State approval of newsletter content.

The following table illustrates the Louisiana quality improvement waiver program model:

Table 1: Quality Improvement Integrated Model: Oversight Roles and Responsibilities[1]

Entities	Membership	Roles and Responsibilities
OBH	Lead/coordinator(s) of the SMO OBH/SMO quality management staff Others from DHH, SMO and other governmental agencies, as need arises	Oversight of QIS. Development of SMO reporting requirements to IMT. Communication and support of stakeholder advisory groups. OBH develops and implements QIS. OBH then integrates the QIS with OBH quality management, SMO QAPI and waiver quality strategies. OBH must work with BHSF as the Medicaid Division and other funding agencies to ensure compliance with federal requirements for funding.
IMT Adult Subcommitee: CSoC Subcommittee	BHSF OBH Waiver participants SMO (Management, Finance, Operations, Quality) _____ BHSF OBH Waiver participants SMO (Management, Finance, Operations, Quality) _____ BHSF OBH DCFS OJJ	The IMT: ▪ Provides oversight and technical support. ▪ Provides forum for best practice sharing. ▪ Provides support and feedback to waiver programs for the: – Establishment of priorities – Identification, design and implementation of quality reporting and monitoring – Review of findings from discovery processes – Development of remediation strategies – Identification and implementation of quality improvement strategies ▪ Provides feedback on quality measurement and improvement strategies to participating agencies and program staff. ▪ Reports to OBH. There are two subcommittees under the IMT: Adult and CSoC/Children. Each are tasked with reviewing data and reporting

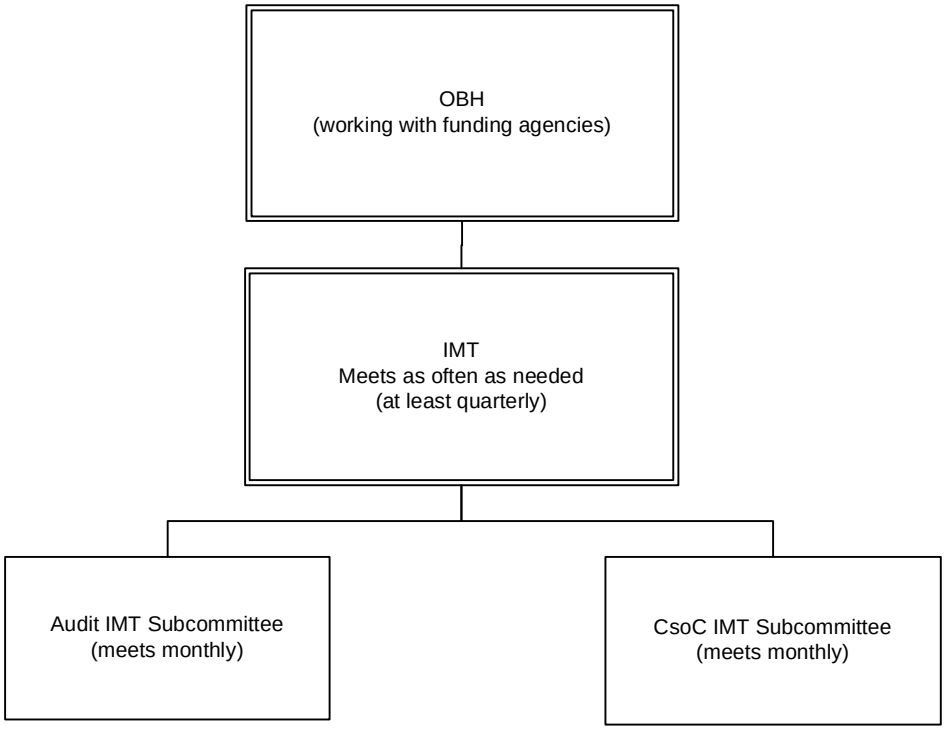
[1] QIS structure is presented on the following two pages

Entities	Membership	Roles and Responsibilities
	DOE Waiver participants SMO (Management, Finance, Operations, Quality)	up to the full committee for feedback and remediation.
State BH Advisory Council and Regional BH Advisory Councils	Providers Advocacy Enrollees/clients State representatives SMO leadership	Reviews QIS efforts Provides forum for input from key stakeholders into quality efforts and key clinical management concerns

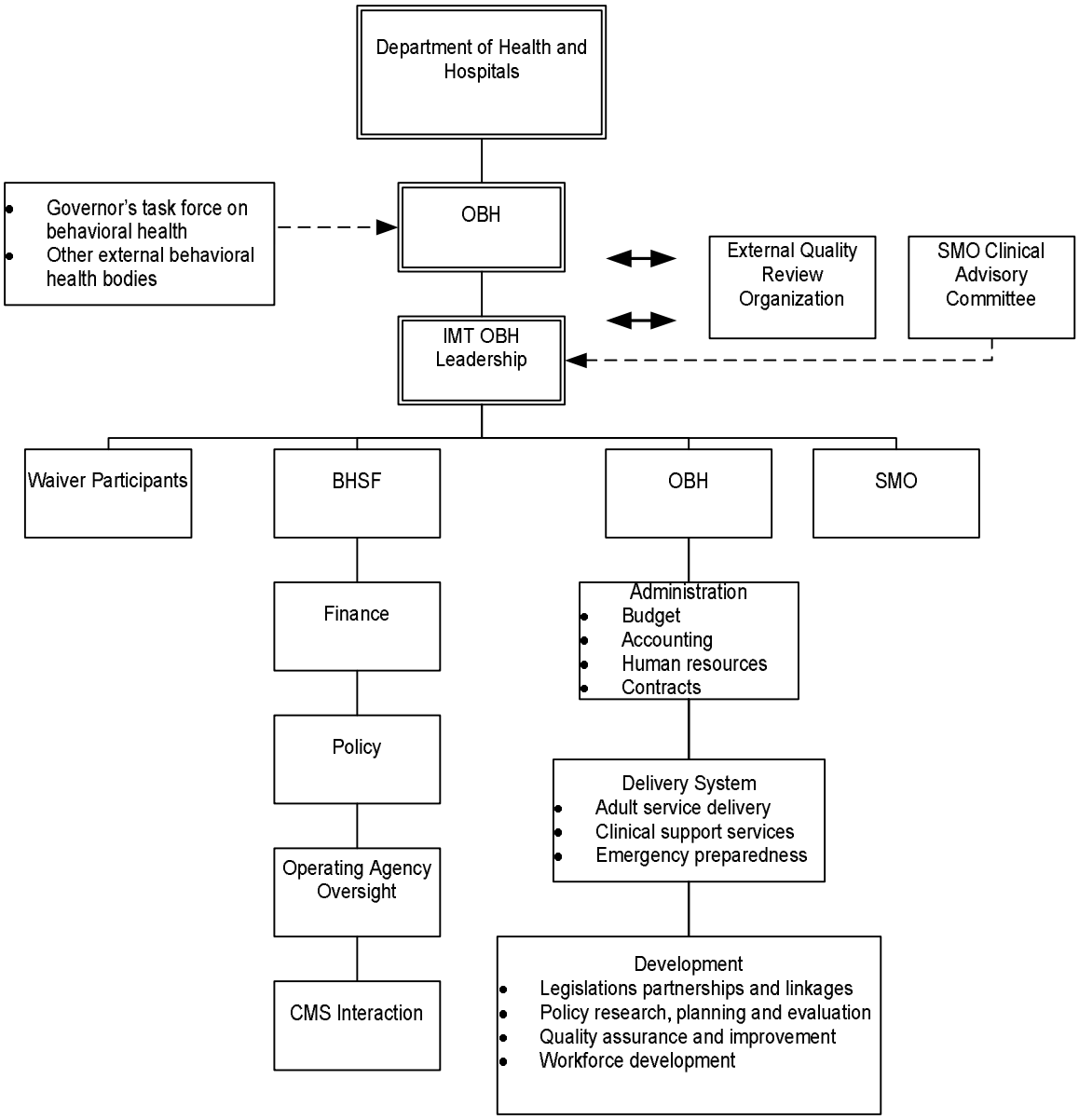
Quality Improvement Structure

The following diagrams visually represent participants of the IMT and the Governance Structure for 1) adults 2) CSoC children and youth 3) Non-CSoC children and youth, demonstrating levels of oversight accountabilities and communication flows. The structure is developed to maximize integration, seek opportunities for collaboration and ensure a rigorous QIS is in place for all waiver populations.

IMT Structure

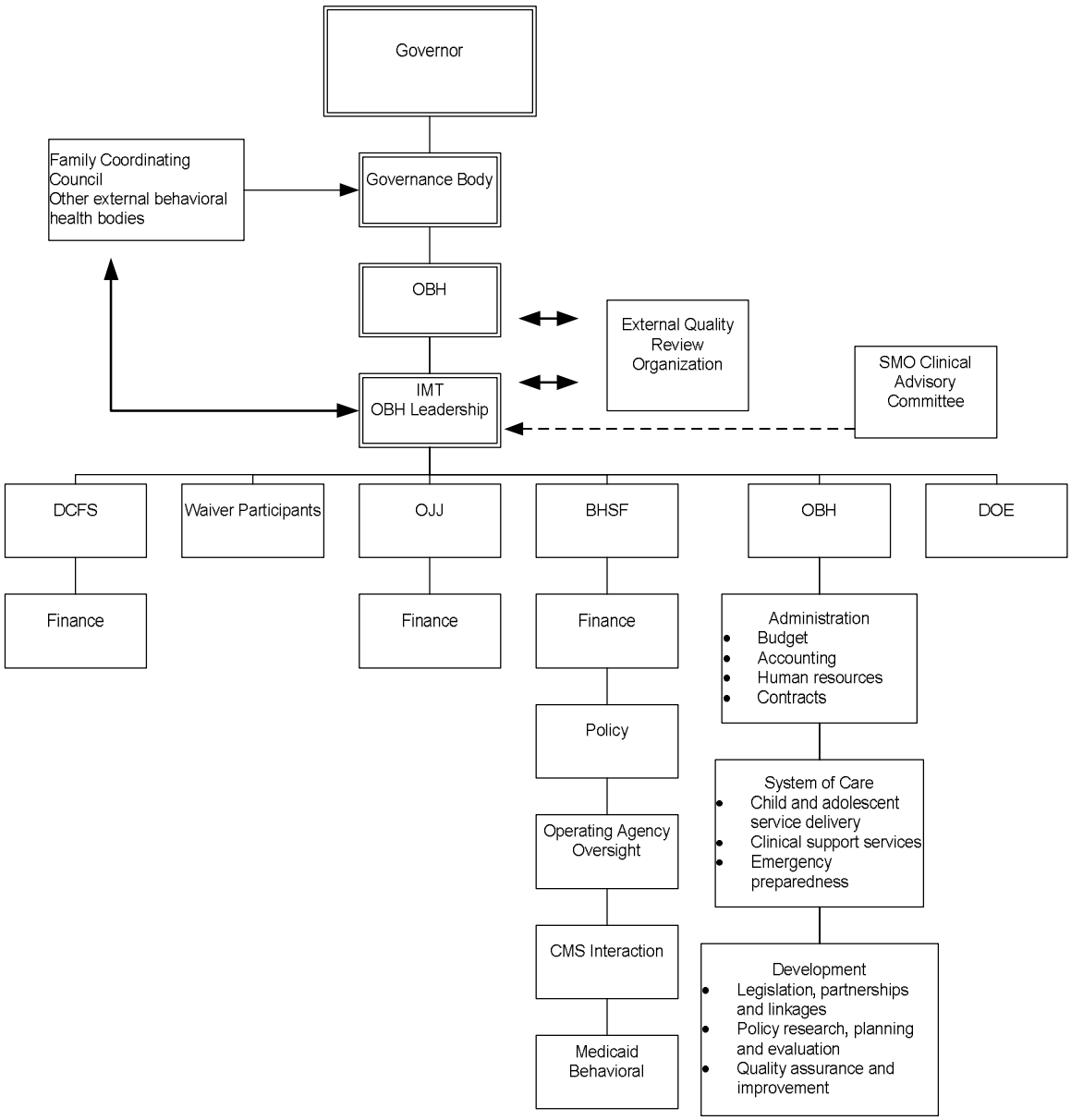


Governance Structure for Adults

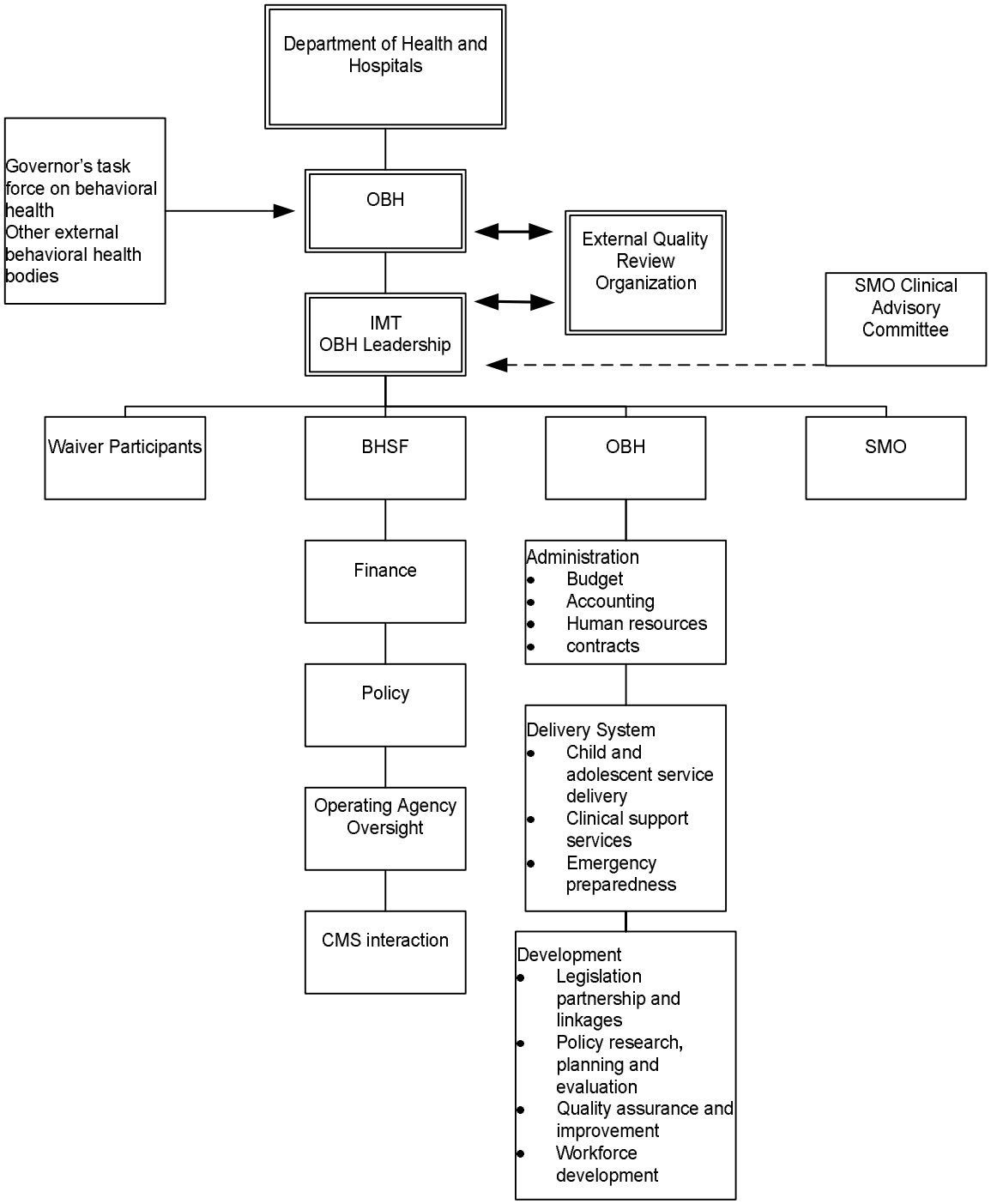


*A clinical advisory committee consisting of licensed network providers is developed by the SMO for consultation on the development of new clinical practice guidelines.

Governance Structure for CSoC Children and Youth



Governance Structure for Non-CSoC Children and Youth



History of Managed Care in Louisiana

From 1999 to 2003, Louisiana's substance abuse and mental health programs came under public scrutiny. Program costs were spiraling out of control, yet access to quality services, particularly in-home and community-based services, was limited in many geographic areas. Client advocates were asking for reform; specifically, they sought to develop a coordinated service delivery system with well-defined service definitions and provider qualifications, as well as methods to track service outcomes.

In 2003, the DHH made the decision to terminate its Medicaid substance abuse program due to concerns about fraud and abuse and cover these services to children under the Office for Addictive Disorders (now part of OBH). DHH also began a complete overhaul of its mental health rehabilitation services, increasing program monitoring, requiring mental health rehabilitation provider agency accreditation, revamping service definitions and developing provider qualifications criteria. While progress was made from 2003 to 2005, the massive hurricanes, which struck Louisiana in 2005 and 2008, brought to light additional service gaps and system inadequacies.

To address these gaps, the OBH (formerly Office of Mental Health) and Medicaid began to develop and implement core service center components of a state owned and operated administrative services organization, addressing such service center component functions as member services, service access and authorization, network services and quality management. As a result of relative success with this management and oversight approach, an amendment to R.S. 40:2017(B) in 2007 was made which stipulated that: "Subject to appropriation by the legislature…the Department of Health and Hospitals shall…establish an administrative services organization for oversight of all behavioral health services."

In November 2009, the State undertook the development of a coordinated system of care for Louisiana's at-risk children and youth with significant behavioral health challenges or co-occurring disorders in, or at imminent risk of, out-of-home placement. Louisiana leaders acknowledged that the needs of these children and families were being served through a fragmented service delivery model, which was, at many times, inadequate and often difficult to navigate. Further, state departments were not ensuring that Medicaid eligible children were receiving Medicaid services when eligible and were not providing a coordinated system of behavioral health services. This too often resulted in Louisiana's children with the highest level of need being placed in residential settings, when community- and home-based alternatives were more appropriate.

The CSoC project is an initiative of Governor Bobby Jindal, led by executives of the OJJ, DCFS, DOE and DHH, inclusive of the OBH. DCFS sponsored a project manager to work with the departmental executives to move the planning process forward. An initial planning retreat was held in January 2009, where over 40 agency and stakeholder leaders, including parents, advocates, providers and community leaders determined the goals, values and population of focus for the CSoC.

Following the retreat, the CSoC leadership team was formalized to include representatives from the governor's office, OJJ, DCFS, DOE, DHH and the Federation for Families for Children's Mental Health, a parent/advocate and an executive of a human service district. The leadership team then established a planning group comprised of 30 individuals representing all four state agencies, the governor's office, juvenile court, advocacy organizations, providers and parents, with over 40% of the membership as external stakeholders.

The leadership team submitted a report to the Louisiana Commission on streamlining government in March 2010, outlining its vision for CSoC development in Louisiana. A website was also established and kept updated with planning group recommendations and other documents as they were produced.

The planning group established 12 topic-focused workgroups, beginning in February 2010, and completed their recommendations in July 2010 regarding the CSoC design, service array, administrative structure and needed infrastructure. The workgroups were open to all interested in participating, with some having over 50 participants. The workgroups shared members and information throughout the planning process to promote cross-collaboration and consistency in their recommendations.

The leadership team outlined an implementation plan in August 2010, based on a multi-departmental, family inclusive governance entity, directing DHH's OBH in serving as the implementing agency. Additional major components of the CSoC structure were the establishment of local care management entities and partnerships with family support organizations. New implementation workgroups, led by agency staff and inclusive of parents and other stakeholder planning group members, were formed to conduct the detailed implementation planning and CSoC start-up activities.

Throughout this process, stakeholder meetings were held monthly to provide all interested individuals progress reports on the CSoC planning efforts and to gain feedback and input. Nine monthly meetings were held between November 2009 and August 2010, with attendance ranging from 20 to 110 individuals.

As a result of these efforts, a comprehensive system for behavioral health services, including a coordinated system of care for at-risk children and youth, was designed. The comprehensive behavioral health system of care is designed to provide an array of services to:

- All eligible children and youth in need of mental health and substance abuse care
- Adults with SPMI or COD of mental illness and substance use
- At-risk children and youth with significant behavioral health challenges or COD in, or at imminent risk of, out-of-home placement

After applying to CMS, DHH is anticipating receiving approval for the 1915(b)(c)(i) authority under the Social Security Act, to be effective October 1, 2011. The authorities increase accountability through expanded oversight and utilization management by a SMO, which is a prepaid inpatient health plan. Statewide uniformity of services across programs has been achieved through the use of standardized practice guidelines, including well-defined service definitions and staff qualifications, evidence-based practices (EBPs), treatment planning and outcome measurement. Because in-home and community services were underutilized, the State is requesting a 1915(b) waiver for mandatory enrollment and selective services authority. Since many of the children outside the CSoC target population and many adults with SPMI or COD are also served by multiple agencies, our aims are to provide quality care in the least restrictive environment, avoiding unnecessary duplication of services and maximizing the use of State funding.

Within the program development process, the State identified system reform goals to support individuals with behavioral health needs in families, homes, communities, schools and jobs. Goals of the system reform include:

- Fostering individual, youth- and family-driven behavioral health services
- Increasing access to a fuller array of evidence-based home- and community-based services that promote hope, recovery and resilience
- Improving quality by establishing and measuring outcomes
- Managing costs through effective utilization of State, federal and local resources
- Fostering reliance on natural supports that sustain individuals and families in homes and communities

To accomplish these goals, the SMO operates a PIHP, as defined in 42 CFR §438.2 and Title 22 of the Louisiana Revised Statutes, to provide the following services:

- Manage behavioral health services for adults with SPMI or COD of mental illness and substance use, on a risk basis, effective on or about October 1, 2011
- Manage mental health and substance use care for all eligible children/youth in need of behavioral health care, on a non-risk basis, effective October 1, 2011
- Implement a CSoC for a subset of children/youth that are in, or at risk of, out-of-home placements on a non-risk basis, effective October 1, 2011. The CSoC will be phased in over the term of the contract through amendments in the State's 1915(c) waiver

Fundamental to implementation of a managed care model is the belief that the use of a managed care system will improve the quality of care delivered in the Medicaid program by consistent application of managed care principles, a strong quality assurance program, partnerships with providers and review and evaluation by an EQRO. Applying these techniques will serve to maintain or improve health outcomes for members by improving consistent access to care and improving the quality of healthcare services by achieving cost-effective service delivery. By expanding partnerships with physicians, practitioners, suppliers, providers, communities and consumers, Louisiana will improve the access, quality and efficiency of behavioral healthcare.

SMO focuses on providing quality behavioral health care to all Medicaid eligible children/youth and adults with SPMI or COD in need of behavioral health care through increased access and appropriate and timely utilization of health care services. For a subset of children/youth that are in, or at risk of, out-of-home placements, a CSoC will be phased in over the term of the contract. Goals and objectives provide a persistent reminder of program direction and scope. As identified in the concurrent 1915 (b) (c) (i) authorities, the State's program goals and the CSoC goals play a significant role in the development of the quality strategy. These goals, which overlap in some areas, are:

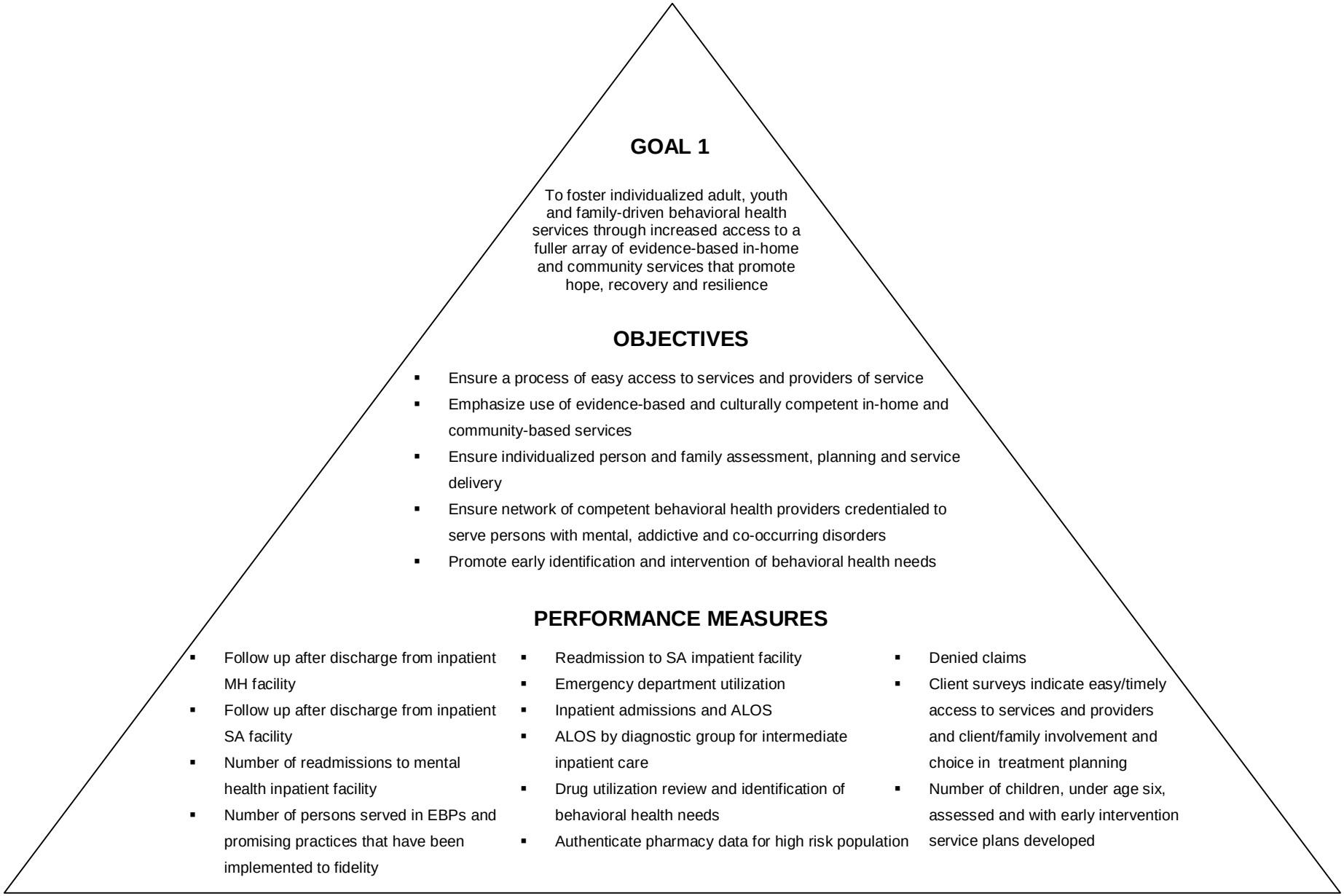
Medicaid program goal 1*:* To foster individualized adult, youth and family-driven behavioral health services through increased access to a fuller array of evidence-based in-home and community services that promote hope, recovery and resilience.

Objectives:

- Ensure a process of easy access to services and providers of service
- Emphasize use of evidence-based and culturally competent in-home and community-based services
- Ensure individualized person and family assessment, planning and service delivery
- Ensure network of competent behavioral health providers credentialed to serve persons with mental, addictive and co-occurring disorders
- Promote early identification and intervention of behavioral health needs

Performance measures:

- Follow up after discharge from inpatient mental health (MH) facility
- Follow up after discharge from inpatient substance abuse (SA) facility
- Number of readmissions to mental health inpatient facility
- Readmission to substance abuse inpatient facility
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Emergency department utilization
- Inpatient admissions and average length of stay (ALOS)
- ALOS, by diagnostic group, for intermediate inpatient care
- Drug utilization review and identification of behavioral health needs
- Authenticate pharmacy data for high risk population
- Denied claims
- Client surveys indicate easy/timely access to services and providers and client/family involvement and choice in treatment planning
- Number of children, under age six, assessed and with early intervention service plans developed



GOAL 1

To foster individualized adult, youth and family-driven behavioral health services through increased access to a fuller array of evidence-based in-home and community services that promote hope, recovery and resilience

OBJECTIVES

- Ensure a process of easy access to services and providers of service
- Emphasize use of evidence-based and culturally competent in-home and community-based services
- Ensure individualized person and family assessment, planning and service delivery
- Ensure network of competent behavioral health providers credentialed to serve persons with mental, addictive and co-occurring disorders
- Promote early identification and intervention of behavioral health needs

PERFORMANCE MEASURES

- Follow up after discharge from inpatient MH facility
- Follow up after discharge from inpatient SA facility
- Number of readmissions to mental health inpatient facility
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Readmission to SA impatient facility
- Emergency department utilization
- Inpatient admissions and ALOS
- ALOS by diagnostic group for intermediate inpatient care
- Drug utilization review and identification of behavioral health needs
- Authenticate pharmacy data for high risk population
- Denied claims
- Client surveys indicate easy/timely access to services and providers and client/family involvement and choice in treatment planning
- Number of children, under age six, assessed and with early intervention service plans developed

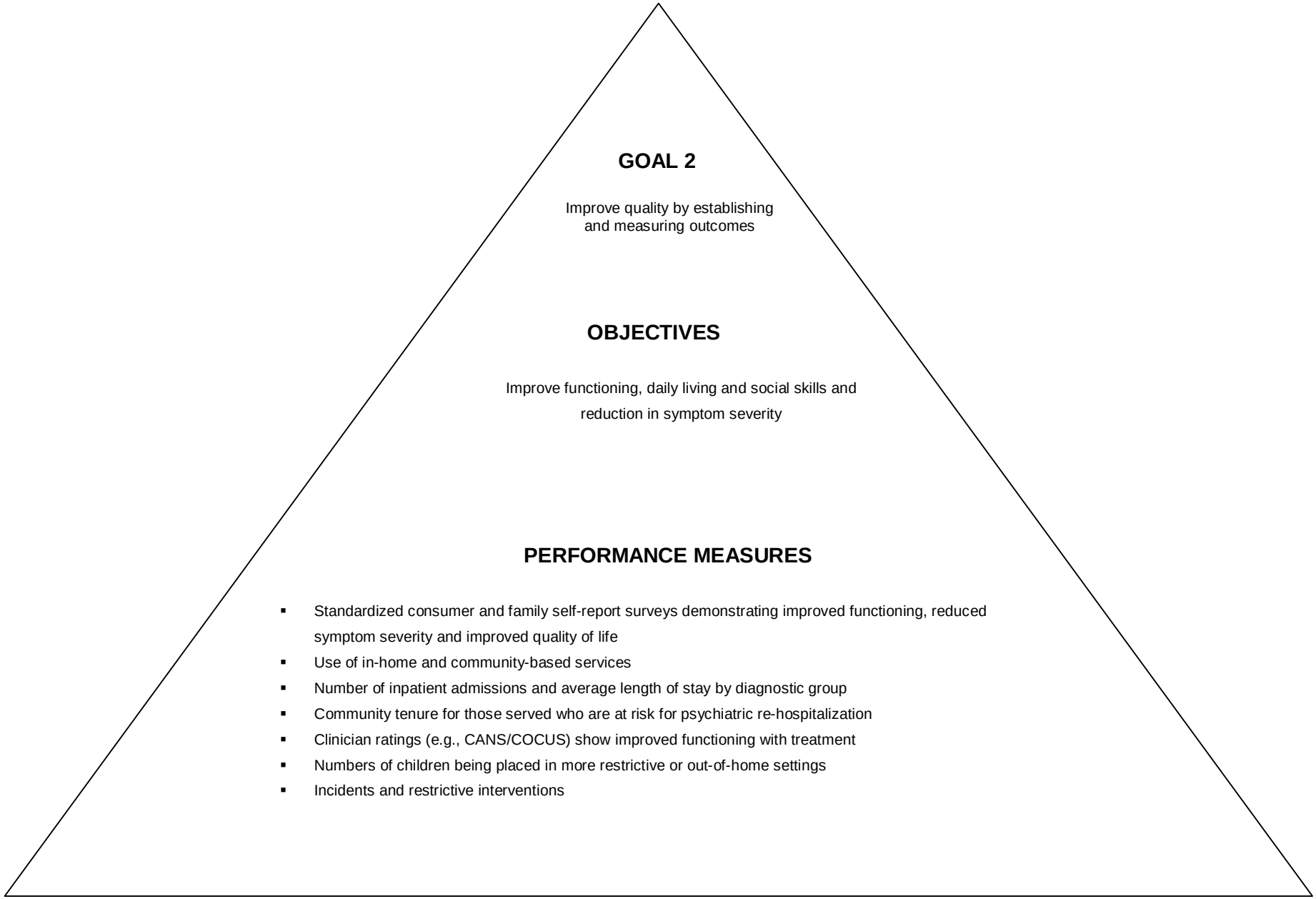
Medicaid program goal 2: Improve quality by establishing and measuring outcomes.

Objectives:

- Improved functioning, daily living and social skills and reduction in symptom severity

Performance measures:

- Standardized consumer and family self-report surveys demonstrating improved functioning, reduced symptom severity and improved quality of life
- Use of in-home and community-based services
- Number of inpatient admissions and ALOS by diagnostic group
- Community tenure for those served, who are at risk for psychiatric re-hospitalization
- Clinician ratings (e.g., Child and Adolescent Needs and Strengths (CANS) assessment show improved functioning with treatment)
- Numbers of children being placed in more restrictive or out-of-home settings
- Incidents and restrictive interventions


GOAL 2
Improve quality by establishing and measuring outcomes
OBJECTIVES
Improve functioning, daily living and social skills and reduction in symptom severity
PERFORMANCE MEASURES
Standardized consumer and family self-report surveys demonstrating improved functioning, reduced symptom severity and improved quality of life
Use of in-home and community-based services
Number of inpatient admissions and average length of stay by diagnostic group
Community tenure for those served who are at risk for psychiatric re-hospitalization
Clinician ratings (e.g., CANS/COCUS) show improved functioning with treatment
Numbers of children being placed in more restrictive or out-of-home settings
Incidents and restrictive interventions

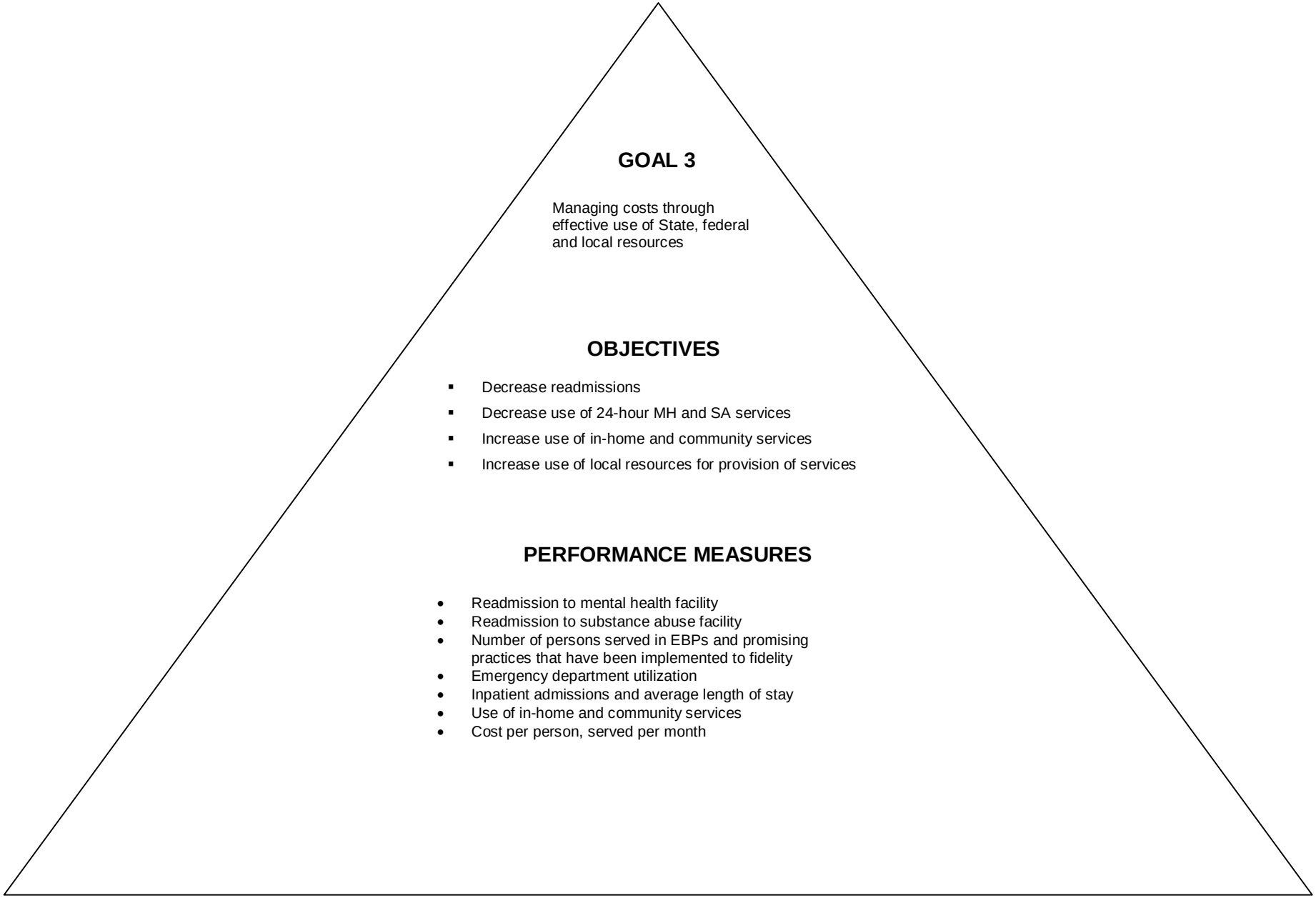
Medicaid program goal 3: Managing costs through effective use of State, federal and local resources.

Objectives:

- Decrease readmissions
- Decrease use of 24-hour MH and SA services
- Increase use of in-home and community services
- Increased use of local resources for provision of services

Performance measures:

- Readmission to mental health facility
- Readmission to substance abuse facility
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Emergency department utilization
- Inpatient admissions and ALOS
- Utilization of in-home and community services
- Cost per person, served per month



GOAL 3

Managing costs through effective use of State, federal and local resources

OBJECTIVES

- Decrease readmissions
- Decrease use of 24-hour MH and SA services
- Increase use of in-home and community services
- Increase use of local resources for provision of services

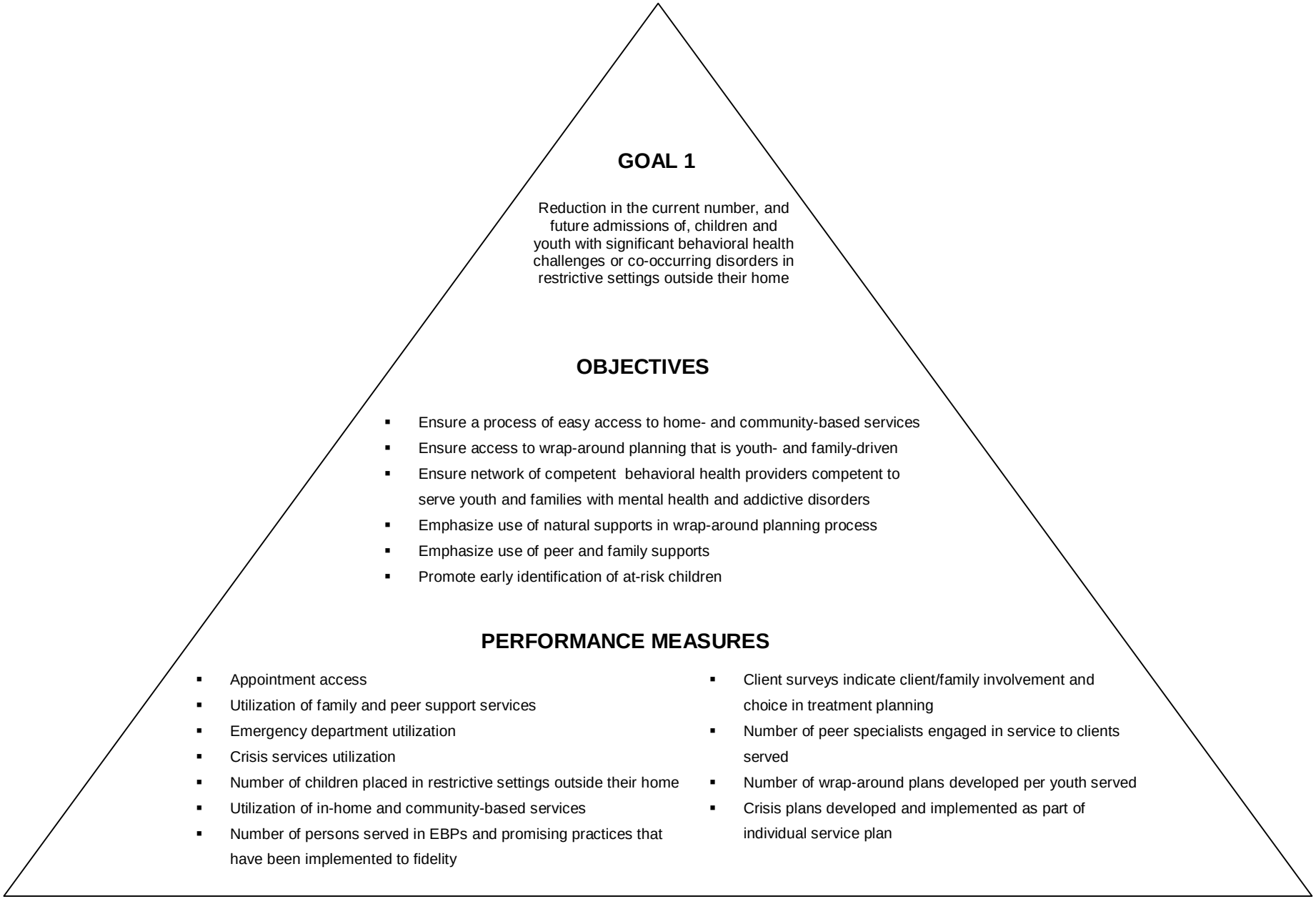
PERFORMANCE MEASURES

- Readmission to mental health facility
- Readmission to substance abuse facility
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Emergency department utilization
- Inpatient admissions and average length of stay
- Use of in-home and community services
- Cost per person, served per month

CSoC goal 1: Reduction in the current number, and future admissions of, children and youth with significant behavioral health challenges or COD in restrictive settings outside their home.

Objectives:
- Ensure a process of easy access to HCBS
- Ensure access to wrap-around planning that is youth- and family-driven
- Ensure network of competent behavioral health providers to serve youth and families with mental health and addictive disorders
- Emphasize use of natural supports in wrap-around planning process
- Emphasize use of peer and family supports
- Promote early identification of at-risk children

Performance measures:
- Appointment access
- Utilization of family and peer support services
- Emergency department utilization
- Crisis services utilization
- Number of children placed in restrictive settings outside their home
- Utilization of in-home and community services
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Client surveys indicate client/family involvement and choice in treatment planning
- Number of peer specialists engaged in service to clients served
- Number of wrap-around plans developed per youth served
- Crisis plans developed and implemented as part of individual service plan



GOAL 1

Reduction in the current number, and future admissions of, children and youth with significant behavioral health challenges or co-occurring disorders in restrictive settings outside their home

OBJECTIVES

- Ensure a process of easy access to home- and community-based services
- Ensure access to wrap-around planning that is youth- and family-driven
- Ensure network of competent behavioral health providers competent to serve youth and families with mental health and addictive disorders
- Emphasize use of natural supports in wrap-around planning process
- Emphasize use of peer and family supports
- Promote early identification of at-risk children

PERFORMANCE MEASURES

- Appointment access
- Utilization of family and peer support services
- Emergency department utilization
- Crisis services utilization
- Number of children placed in restrictive settings outside their home
- Utilization of in-home and community-based services
- Number of persons served in EBPs and promising practices that have been implemented to fidelity
- Client surveys indicate client/family involvement and choice in treatment planning
- Number of peer specialists engaged in service to clients served
- Number of wrap-around plans developed per youth served
- Crisis plans developed and implemented as part of individual service plan

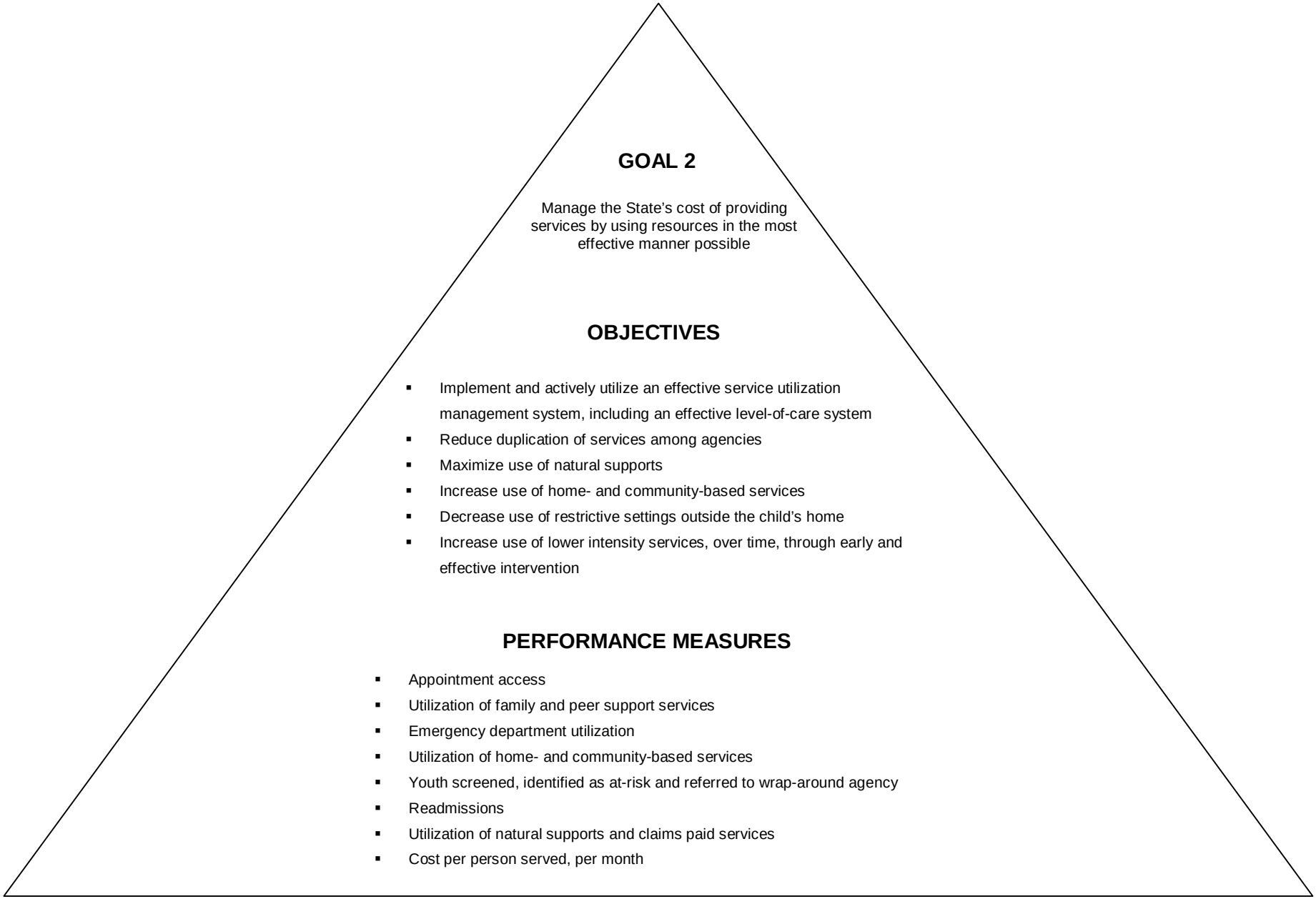
CSoC goal 2: Manage the State's cost of providing services by using resources in the most effective manner possible.

Objectives:

- Implement and actively utilize an effective service utilization management system, including an effective level-of-care system
- Reduce duplication of services among agencies
- Maximize use of natural supports
- Increase use of HCBS
- Decrease use of restrictive settings outside the child's home
- Increase use of lower intensity services, over time, through early and effective intervention

Performance measures:

- Appointment access
- Utilization of family and peer support services
- Emergency department utilization
- Utilization of HCBS
- Youth screened, identified as at-risk and referred to wrap-around agency
- Readmissions
- Utilization of natural supports and claims paid services
- Cost per person served, per month



GOAL 2

Manage the State's cost of providing services by using resources in the most effective manner possible

OBJECTIVES

- Implement and actively utilize an effective service utilization management system, including an effective level-of-care system
- Reduce duplication of services among agencies
- Maximize use of natural supports
- Increase use of home- and community-based services
- Decrease use of restrictive settings outside the child's home
- Increase use of lower intensity services, over time, through early and effective intervention

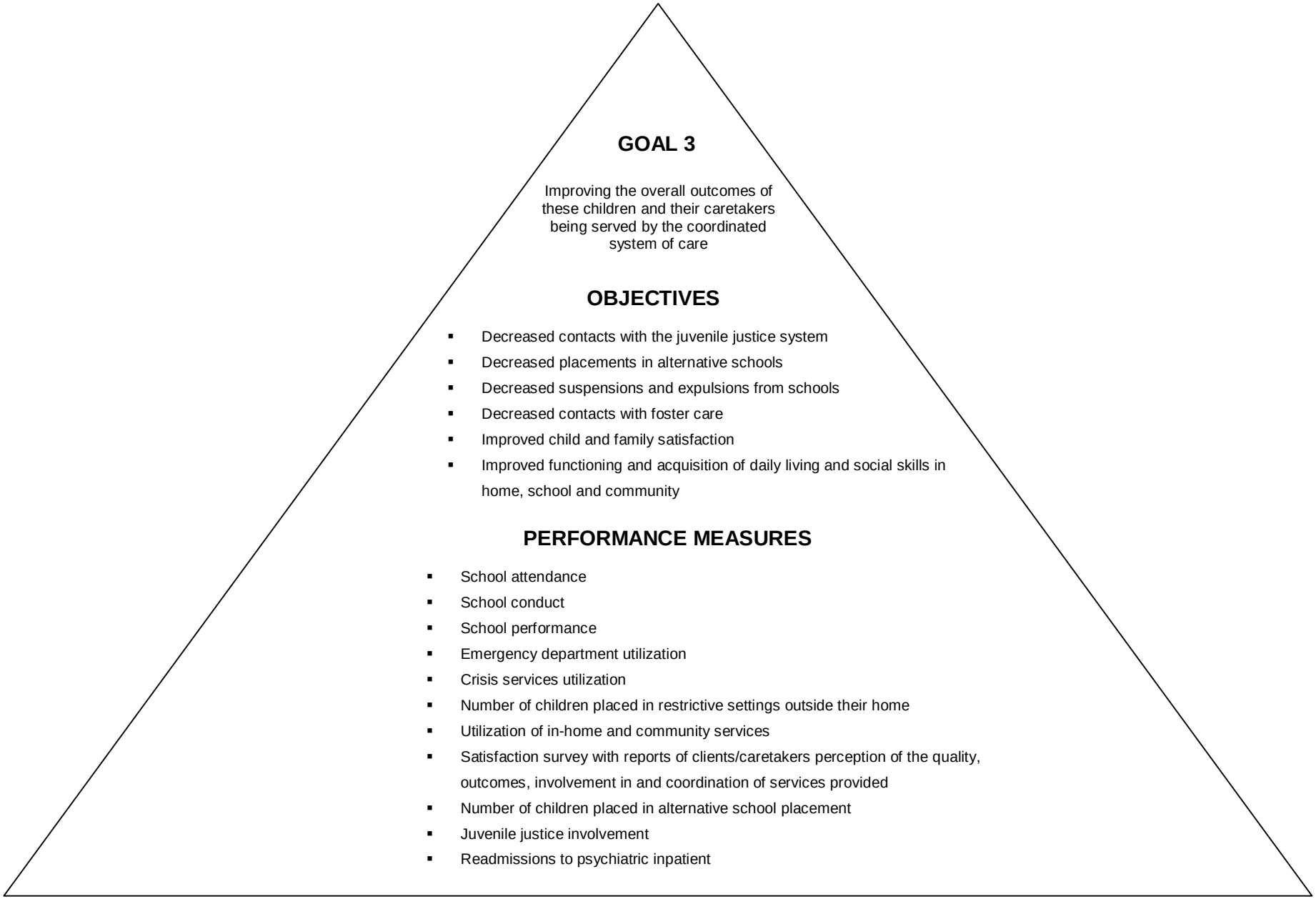
PERFORMANCE MEASURES

- Appointment access
- Utilization of family and peer support services
- Emergency department utilization
- Utilization of home- and community-based services
- Youth screened, identified as at-risk and referred to wrap-around agency
- Readmissions
- Utilization of natural supports and claims paid services
- Cost per person served, per month

CSoC goal 3: Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care.

Objectives:
- Decreased contacts with the juvenile justice system
- Decreased placements in alternative schools
- Decreased suspensions and expulsions from schools
- Decreased contacts with foster care
- Improved child and family satisfaction
- Improved functioning and acquisition of daily living and social skills in home, school and community

Performance measures:
- School attendance
- School conduct
- School performance
- Emergency department utilization
- Crisis services utilization
- Number of children placed in restrictive settings outside their home
- Utilization of in-home and community services
- Satisfaction survey with reports of clients/caretakers perception of the quality, outcomes, involvement in and coordination of services provided
- Number of children placed in alternative school placement
- Juvenile justice involvement
- Readmissions to psychiatric inpatient



GOAL 3

Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care

OBJECTIVES

- Decreased contacts with the juvenile justice system
- Decreased placements in alternative schools
- Decreased suspensions and expulsions from schools
- Decreased contacts with foster care
- Improved child and family satisfaction
- Improved functioning and acquisition of daily living and social skills in home, school and community

PERFORMANCE MEASURES

- School attendance
- School conduct
- School performance
- Emergency department utilization
- Crisis services utilization
- Number of children placed in restrictive settings outside their home
- Utilization of in-home and community services
- Satisfaction survey with reports of clients/caretakers perception of the quality, outcomes, involvement in and coordination of services provided
- Number of children placed in alternative school placement
- Juvenile justice involvement
- Readmissions to psychiatric inpatient

2

Assessment: Quality and Appropriateness of Care

Procedures for Race, Ethnicity, Primary Language and Data Collection

The SMO contract includes language requirements compliant with federal regulations 42 CFR 438.204(f): An information system (IS) that supports initial and ongoing operation and review of the State's quality strategy.

- ***Data collection:*** During the Medicaid eligibility application process, the applicant may identify race, ethnicity and primary spoken language. In accordance with the Bureau of Census reporting standards, the data collected for race/ethnicity is passed daily from the Medicaid eligibility data system to the Medicaid management information system (MMIS). Primary language spoken is also forwarded from the eligibility system to the MMIS. Because this is voluntary disclosure, until the Medicaid eligibility process implements mandatory disclosure of race/ethnicity and primary language, the State relies on demographic updates to the eligibility system. Although this method does not collect 100% of the required data, there are data for a significant portion of the population served.

- ***Communication with SMO:*** The SMO is notified of client enrollment/disenrollment information at least monthly, via an enrollment report, in the form of an 834 HIPAA-compliant enrollment data file. The file is electronically transmitted on or before the first day of each enrollment month. It includes clients newly enrolled and clients continuing to be enrolled. The SMO is responsible for payment of the covered services for each enrolled client. To facilitate care delivery appropriate to client needs, the enrollment file also includes race/ethnicity and primary language spoken. The SMO will use information on race/ethnicity and language to engage individuals who might otherwise not use services by:

- Providing interpretive services to facilitate access when staff does not speak the language of the participant
- Developing educational materials and providing employee training on cultural competence
- Hiring culturally and linguistically competent staff
- Expanding network services to include culturally competent providers

Mechanisms the State Uses to Identify Persons with Special Healthcare Needs to Managed Care Organizations

The special health care needs population is defined as:

- Children and youth under age 22 that have significant behavioral health challenges or co-occurring disorders that are in, or at imminent risk of, out-of-home placement (functionally eligible for the CSoC program)
- Children with behavioral health needs in contact with other child serving systems
- Adults eligible for the 1915(i) HCBS services
- Any individual with IV drug user, pregnant substance abuse user, substance abusing women with dependent children or dual diagnosis

Adults eligible to receive 1915(i) State Plan services include adults over the age of 21 who meet one of the following criteria is eligible to receive State Plan HCBS services:

- Persons with acute stabilization needs
- Persons with serious mental illness (federal definition of serious mental illness)
- Persons with major mental disorder
- An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.

The SMO contract requires focused coordination for the treatment programs of those who are considered high risk or high utilizers; the Contractor shall identify people with high needs and initiate ongoing treatment planning and service coordination with the consumer and others working with the consumer. The Contractor will be required to work, in concert, to address the needs of dually diagnosed individuals.

The SMO contract requires the SMO to implement mechanisms to assess each Medicaid enrollee identified above as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. For enrollees with special health care needs, who need a course of treatment or regular care monitoring, the State requires the SMO to produce a treatment plan. If so, the treatment plan must meet the following requirements:

- Developed by the enrollee's primary care provider with enrollee, family and treatment team participation and in consultation with any specialists providing care for the enrollee. If the primary care provider chooses not to participate in the development of the behavioral health treatment plan, ongoing communication with the primary care provider is required to be documented by the SMO or its subcontractor. In particular, any changes in medication or critical incidents associated with the special health care needs individual must be communicated with the primary care provider.
- Approved by the SMO in a timely manner (if approval required by plan).
- In accordance with any applicable State quality assurance and utilization review standards.

If a treatment plan or regular care monitoring is in place, the SMO has a mechanism in place to allow enrollees to directly access specialists, as appropriate for enrollee's condition and identified needs.

To ensure individual treatment plans are developed consistent with 42 CFR Part 438.208 and Part 456, and to ensure enrollee participation in the treatment planning process:

- The SMO shall determine which behavioral health services are medically necessary for each enrollee.
- The SMO shall determine, at the initial contact, if the child/youth is eligible for referral to the CSoC for further assessment; if eligible, refer the child/youth and their family/caregiver to the Wraparound Agency (WAA) for assessment, individual service planning and immediate access to services and supports; and, if ineligible for the CSoC, refer the child/youth and family/caregiver to providers offering clinically appropriate and medically necessary services.
- The SMO shall perform quality monitoring of the behavioral health services provided to enrollees by network providers.
- The SMO shall coordinate behavioral health hospital and institutional admissions and discharges, including ensuring that each institution begins discharge planning on the day of admission.
- The SMO shall coordinate its services with the services enrollees receive from other health care providers, managed care entities and other State agencies in order to avoid unnecessary duplication. This will include coordination of care with each enrollee's primary care provider, WAA and family service organization (if applicable).
- The SMO shall provide follow-up activities to high-risk enrollees who do not appear for scheduled appointments; to enrollees for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; and to individuals discharged from 24-hour care.
- The SMO shall ensure that each enrollee's privacy is protected, in accordance with State and federal law.
- The SMO shall share, with the coordinated care network (CCN), or other managed care entity, serving the enrollee with special health care needs, the results of its

identification and assessment of that enrollee's needs to prevent duplication of those activities.

Clinical Guidelines

The SMO Must Adopt Practice Guidelines That Meet the Following Requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the enrollees
- Are adopted in consultation with contracting health care professionals
- Are reviewed and updated periodically, as appropriate

The SMO shall develop a Clinical Advisory Committee (CAC) consisting of qualified service network providers. SMO practice guidelines and others the SMO chooses to adopt, in consultation with this committee, in collaboration with DHH/CSoC and following approval by OBH, shall be reviewed and updated annually. The SMO shall implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the adopted practice guidelines. At a minimum, the SMO shall annually monitor practice guidelines implementation through peer review processes and collection of fidelity measures.

The SMO shall use the practice guidelines as a basis for decision regarding utilization management, enrollee education, coverage of services and other areas to which the practice guidelines apply.

The SMO shall disseminate the practice guidelines to the WAA and all affected providers and, upon request, to enrollees and potential enrollees. The SMO shall also provide the WAA and qualified service providers with technical assistance, training and other resources to implement practice guidelines.

External Quality Review

Annually, the independent EQRO will analyze the results of review activities under the mandatory protocols conducted by the State and its contractors and write an official EQR report. The federal and State regulatory requirements and performance standards, as they apply to SMOs, will be evaluated annually for the State in accordance with 42 CFR 438.310 by an independent EQRO, including a review of the services covered under each SMO contract for timeliness, outcomes and accessibility, using definitions contained in 42 CFR 438.320. The annual EQR will be conducted for each calendar year, with the first EQR report including any months prior to the first full calendar year of operation.

The EQRO competence and independence requirements are used as criteria in selecting an entity to perform the review, as mentioned in 42 CFR 438.354 and 42 CFR 438.356(b) and (d), using the rates, as described in 42 CFR 433.15(b)10 and

42 CFR 438.370. To ensure competence, the EQRO must have staff with demonstrated experience and knowledge of the Medicaid program, SMO delivery systems, QM methods and research design and statistical analysis. The EQRO must have sufficient resources to conduct needed activities and other skills necessary to carry out activities or supervise any subcontractors. To ensure independence, the EQRO must not be an entity that has Medicaid purchasing or managed care licensing authority; governed by a body in which the majority of its members are government employees; reviewing a public health institute, in which the EQRO has a control position or financial relationship by stock ownership, stock options, voting trusts, common management or contractual relationships; delivering any services to Medicaid recipients or conducting other activities related to the oversight of the quality of SMO services, except for those specified in 438.358. EQROs are permitted to use subcontractors; however, the EQRO is accountable for and must oversee all subcontractor functions, as mentioned in 42 CFR 438.356(c).

The specification of activities to be performed by the EQRO broadly includes measurement of quality and appropriateness of care and services and synthesis of results compared to the standards and recommendations based on the findings. The EQRO will meet these obligations by utilizing the information gathered by the State and its contractors, as well as any information the EQRO gathers from EQR protocols developed by CMS to perform the mandatory activities required of EQROs, as mentioned in 42 CFR 438.352 and 438.358, including data to be gathered, data sources, activities to ensure accuracy, validity and reliability of data, proposed data analysis and interpretation methods and documents and/or tools necessary to implement the protocol. The State will ensure the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in the regulation, as mentioned in 42 CFR 438.350. This information will be obtained through methods consistent with established protocols, include the elements described in the EQR results section, and results will be made available, as specified in the regulation.

CMS-published protocols are utilized by the organization conducting the EQR activities.

Mandatory EQRO activities conducted by the State of Louisiana IMT staff and its contractors, as mentioned in
42 CFR 438.358, include:

- Validation of PIPs
- Validation of PMs reported by the SMO
- Review within the previous three-year period to determine the SMO’s compliance with standards for access to care, structure and operations and quality measurement and improvement

Methods outlined in the EQR protocol include:

- Medical chart reviews
- SMO case management file reviews
- Provider surveys

- Data analysis
- Administrative oversight and quality assessment and improvement review
- Focused studies of certain aspects of care

The EQRO produces at least the following information, as required in 42 CFR 438.364(a), without disclosing the identity of any patient, as mentioned in 42 CFR 438.364(c):

- A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness and access to care furnished by the SMO. For each activity conducted, the report does include objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- Recommendations for improving the quality of health care services furnished by the SMO.
- An assessment of the degree to which the SMO effectively addresses previous EQRO review recommendations. The EQRO does provide this information by:
  - Holding a review exit conference with the State and SMO administrative and clinical management staff to address findings and recommendations
  - Providing a written summary of reports, including findings and recommendations to the State and SMO

The State 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, as mentioned in 42 CFR 438.364(b). The State will provide copies of the EQRO results and reports to CMS.

EQR results and technical reports are reviewed by the IMT for feedback. Ongoing EQR status reports and final technical and project reports are communicated through the IMT. Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements, PMs or PIPs. Report results are also used to determine levels of compliance with requirements and to assist in identifying next steps.

The EQR technical report provides detailed information regarding the regulatory compliance of the SMO, as well as results of PIPs and PMs. Report results provide information regarding the effectiveness of the quality management organization’s program, identify strengths and weaknesses and provide information about problems or opportunities for improvement. This information is utilized for input into the QIS and for initiating and developing quality improvement projects.

If the SMO is deemed non-compliant during any aspect of the EQR process, a corrective action plan is developed to address areas of noncompliance, including a timeline for achieving compliance. The IMT provides ongoing monitoring of the corrective action plan during a joint meeting with the SMO.

Performance Measures and Performance Improvement Projects

CMS, in consultation with states and other stakeholders, may specify PMs and topics for PIPs to be required by states in their contracts with SMOs. OBH, in conjunction with the IMT has identified several PMs and two PIPs that address a range of priority issues for the Medicaid population. These measures have been identified through a process of data analysis and evaluation of trends within the Medicaid population. Consumer, advocate and provider input were accessed throughout the design process for the comprehensive system for behavioral health services, including the CSoC for at-risk children and youth. Final approval of PMs is the responsibility of OBH for adults and non-CSoC children, and the CSoC governance board for CSoC children. For measures with a representative sample (less than 100%), the State will use a simple random sample of a size that results in a 95% confidence interval (i.e., margin of error +/- 5%). The performance measure results will be reviewed annually, and benchmarked with established performance standards/goals and reviewed in IMT meetings. Consumer, advocate and provider input will be accessed through regular meetings, including:

- CSoC governance meetings.
- Family Advisory Committee family meetings.
- Internal IMT meetings (coordination between DHH, the SMO and other state agencies).

SMO Performance Measures

The following demonstrates selected SMO PMs that are directed at achieving waiver goals. Examples of additional PMs that are monitored and will be validated by the EQRO are:

- Appointment access (routine, urgent, emergent)
- Increased use of home- and community-based services and decreased use of 24-hour levels of care and out-of-home placements
- Resolution of complaints, grievances and appeals
- Percent of natural supports versus paid services in the service plan (CSoC)

SMO Performance Improvement Projects

In accordance with 42 CFR 438.240, the SMO must have an ongoing program of PIPs that focus on clinical and non-clinical areas. A PIP is intended to improve the care, services or member outcomes in a focused area of study.

OBH requires the following PIPs. The first year of the contract, SMO will implement one non-clinical and one clinical PIP. The non-clinical project for the first year is appointment access, and the clinical topic is the number of CSoC treatment plans with service authorization at first review. During year two of the contract, the SMO will implement an additional performance improvement project for a total of three PIPs. For year three of the contract, the SMO will implement a fourth non-clinical PIP. The project

topics for year one were determined by OBH. The additional topics for years two and three will be determined jointly by OBH and the SMO.

PIPs
Appointment access: routine, urgent and emergent
Number of CSoC treatment plans with service authorization at first review

Intermediate Sanctions

The premise behind the QIS process is one of continuous quality improvement. Louisiana strongly believes in working with its SMO in a proactive manner to improve the quality of care received by Louisiana Medicaid beneficiaries. However, should the need arise, part of the Louisiana quality improvement process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. Because the SMO is a PIHP and not a managed care organization (MCO) per 42 CFR 438.2, these sanctions do not need to meet the federal requirements of 42 CFR Part 438 Subpart I. However, Louisiana has chosen to implement most, if not all, of those federal sanctions under State authority to ensure contractual compliance. Louisiana has included the following sanctions and conditions for termination to meet State requirements for sanctions and terminations.

OBH will have the right to impose penalties and sanctions, arrange for temporary management as specified below or immediately terminate the SMO contract under conditions specified below, independent of the actions of the IMT.

Prepaid Inpatient Health Plan Breach; Remedies

If the SMO breaches the terms of the contract, OBH may issue a written notice of breach to the SMO, describing the breach and requiring the SMO to submit to OBH, within 30 days, a corrective action plan for OBH's approval. If the SMO does not cure the breach in a timely manner and to OBH's satisfaction, OBH may impose one or more, or all, of the sanctions listed below:

- The suspension, recoupment or withholding of monthly capitation payments
- The assessment of refundable or non-refundable penalties
- The assessment of monetary damages
- The termination of this contract

Notwithstanding the foregoing, OBH may impose any of these sanctions or any other available sanctions against the SMO without first giving the SMO an opportunity to cure the deficiency.

Termination for Cause

- The SMO, or one of its subcontractors or providers, has substantially failed to comply with the material terms of this contract, and the SMO fails to take appropriate action, immediately, to correct the problem.

- The SMO, or one of its subcontractors or providers, has substantially failed to comply with the applicable requirements of Sections 1932 of the Social Security Act, and the SMO fails to take appropriate action, immediately, to correct the problem.
- The SMO, or one of its subcontractors or providers, has substantially failed to comply with the requirements of any other State or federal Medicaid statute, rule or regulation, and the SMO fails to take appropriate action, immediately, to correct the problem.
- The performance of the SMO, or one of its subcontractors or providers, threatens to place the health or safety of any enrollee in jeopardy, and the SMO fails to take appropriate action, immediately, to correct the problem.
- The SMO becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p).
- The SMO, or one of its subcontractors or providers, fraudulently misleads any enrollee or fraudulently misrepresents the facts or law to any enrollee, and the SMO fails to take appropriate action, immediately, to correct the problem.
- Gratuities of any kind are offered to or received by any public official, employee or agent of the State by or from the SMO, its agents, employees, subcontractors or providers.

Penalties, Sanctions and Temporary Management

- OBH has defined performance guarantees that are subject to penalties. These performance guarantees and the process for administering penalties and sanctions are defined in Section IV of the Request for Proposal (RFP)/Contract under Contractual Requirements.
- The contract may be terminated by either party upon giving 30 days advance written notice to the other party with or without cause, but in no case shall continue beyond the specified termination date.
- If the contract is cancelled or terminated, OBH reserves the right to purchase materials or to complete the required work. OBH may recover any reasonable excess costs resulting from contract cancellation or termination from the Contractor by:
  - Deduction from an unpaid balance
  - Collection against the performance bond
  - Any combination of the above or any other remedies as provided by law
- In the event the contract or any portion thereof is terminated for any reason, or expires, the Contractor shall assist the OBH in the transition of its members to another Contractor at the Contractor's own expense.
- The Contractor shall cooperate with the OBH during the planning and transition of contract responsibilities from the Contractor to a replacement Contractor or the OBH. The Contractor shall ensure that member services are not interrupted or delayed during the remainder of the contract, and the transition planning by all parties shall be cognizant of this obligation. The Contractor shall:
  - Make provisions for continuing all management and administrative services and the provision of services to members until the transition of all members is completed and all other requirements of this contract are satisfied.

  - Designate the program manager for the contract as the transition coordinator. The transition coordinator shall interact closely with the OBH and the staff from the new Contractor to ensure a safe and orderly transition and shall participate in all transition meetings.
  - Upon OBH request, submit for approval a detailed plan for the transition of its members, including the name of the transition coordinator.
  - Provide all reports set forth in this contract and necessary for the transition process.
  - Notify providers, subcontracts and members of the contract termination, as directed by OBH, including transfer of provider network participation to OBH or its designee.
  - Complete payment of all outstanding obligations for covered services rendered to members. The Contractor shall cover continuation of services to members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.
  - Cooperate fully with a successor Contractor and OBH during the transition period including, at a minimum, sharing and transferring behavioral health member information and records, as required by the OBH.
  - Transfer the toll-free call center line telephone numbers to OBH or the successor Contractor to allow for the continuous use of the number for member services and Provider services.
  - Return to the OBH within 30 days of termination of the contract any funds advanced to the Contractor for coverage of members for periods after the date of termination. Supply all information necessary for reimbursement of outstanding claims.
- The detailed plan for transition shall ensure an orderly transfer of responsibility and/or the continuity of those services required under the terms of the contract to a new Contractor or the OBH, and shall include the following:
  - A realistic schedule and timeline to hand off responsibilities to the replacement Contractor or the OBH.
  - Staff that shall be utilized during the hand off of duties and their responsibilities, such that there shall be clear lines of responsibility between the Contractor, the replacement Contractor and/or the OBH.
  - Actions that shall be taken by the Contractor to cooperate with the replacement Contractor and/or the OBH to ensure a smooth and timely transition.
  - The Contractor shall develop a plan on how to best inform and keep Contractor employees during the transition.
  - A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task; the start and deadline dates to complete the planned task; and a place to record completion of the task.
  - All information necessary for reimbursement of outstanding claims.
  - The Contractor shall report, in writing, to the State Contract Monitor and within 48 hours, any problems and corrective actions taken regarding the plan for transition.
  - The Contractor shall participate in a transition planning team as established by the OBH. The Contractor’s transition planning team shall include program

evaluation staff and program monitoring staff, as well as staff that support all automated and computerized systems and databases.

- The Contractor shall complete all work in progress and all tasks called for by the plan for transition prior to final payment to the Contractor. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved prior to termination of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items, the cost to complete these items will be deducted from the final payment or withheld from the performance bond. The Contractor shall specify a process to brief the OBH or replacement Contractor on issues before the hand off of responsibilities.
- The expiration or termination or suspension shall not affect the obligation of the Contractor to indemnify the OBH for any claim by any third party against the State or the OBH arising from the Contractor's performance of this contract and for which the Contractor would otherwise by liable under this contract.
- The Contractor shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management subcontracts, in writing, to stop all work as of the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this contract and in accordance with a written plan approved by the OBH for the orderly transition of members to another Contractor. Unless otherwise directed by the OBH, the Contractor shall direct subcontracted providers to continue to provide services consistent with the member's treatment plan or plan of care.

State Standards

In an effort to provide appropriate access to Louisiana's Medicaid population, all standards for access to care, structure and operations, and quality measurement and improvement listed in the tables below and throughout the QIS document are incorporated in the SMO contract/RFP, which is in accordance with federal regulations.

Appointment Standards, Availability and Wait Times

Appointment Standards	
Appointment Availability	Appointment Wait Times
Emergent appointments: Providers must provide face-to-face emergency care within one hour after a request for care is received.	Emergencies: Within one hour after the request for care is initiated; life-threatening emergencies shall be managed immediately.
Urgent appointments: Providers must provide initial face-to-face assessments and/or treatment within 48 hours after the day and time a request of care is received.	Urgent: Within 48 hours of referral.

Routine appointments: Providers must provide initial face-to-face assessments/and or treatment within 10 working days (14 calendar days).	Routine: Within 14 calendar days.

Access Standards

Performance Standards
Delivery Network
Contracted network of appropriate providers (42 CFR 438.206(b)(1)) ▪ The Contractor is required to provide at least as much access to services as exist within Medicaid's FFS program. ▪ Within the Plan's provider network, recipients have a choice of the providers which offer the appropriate level of care. ▪ The Contractor shall comply with La. R.S. 40:2201 et seq, La. R.S. 40:2211 et seq and La. R.S. 40:2242, which speak to participation of essential community providers. ▪ Rehabilitation providers shall be employed by a rehabilitation agency, school or clinic licensed and/or certified and authorized under State law to provide these services. ▪ Rehabilitation agencies shall be certified by DHH. Mental health and/or addiction clinics shall meet the licensure standards for psychiatric facilities providing clinic services as determined by the BHSF. ▪ The Contractor will be encouraged to collaboratively develop networks with service accessibility and be required to sub-contract with providers necessary to fill any service gaps existing in the Contractor's network. ▪ Enrollees will have free choice of providers within the Contractor network and may change providers. ▪ In addition, if an enrollee needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available. ▪ The Contractor shall develop and maintain a comprehensive network that is consistent in size and variety with the existing statewide FFS network and the existing contracted providers' network, offering services through OBH, DCFS, DOE, OJJ, the Office of Citizens with Development Disabilities (OCDD) (nursing facilities for individuals age 21 and under with behavioral health challenges) on or before the Contract start date. ▪ The Contractor shall maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the entity shall consider the following: – The anticipated Medicaid enrollment – The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular contract – The number and types (in terms of training, experience and specialization) of

providers required to furnish the contracted Medicaid services
  - The number of network providers who are not accepting new Medicaid patients
  - The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities
- The Contractor shall submit the documentation ensuring adequate capacity and services as specified by the State and, specifically, as follows, but no less frequently than:
  - At the time it enters into a contract with the State
  - At any time there has been a significant change (defined as more than 1% change in the Contractor's network) in the Contractor's operations that would affect adequate capacity and services and also including changes in services, benefits, geographic service area or payments, or enrollment of a new population with the Contractor
  - Annually, the Contractor shall submit documentation to the State to demonstrate, in a format specified by the State, that it:
    - Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service area
    - Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area

Adequate and timely second opinion (42 CFR 438.206(b)(3))

- If requested, the Contractor shall offer a second opinion from a qualified health care professional within the network or arrange for a second opinion outside the network at no cost to the member.
- The Contractor shall make members and families/caregivers, WAA, Family Support organizations (FSOs) and qualified service providers aware of the availability of second opinions and provide second opinions at no cost to the behavioral health member.

Adequate and timely out-of-network providers (42 CFR 438.206(b)(4) & (b)(5))

- If the Contractor's network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out-of-network for the member for as long as the Contractor is unable to provide them. When the Contractor is not able to deliver a medically necessary covered behavioral health service, the Contractor shall in a timely manner subcontract with an out-of-network provider to deliver the same service until a network provider is available. The Contractor shall expeditiously authorize services and reimburse the out-of-network provider in these circumstances.
- In addition, if a member needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available.

- If the Contractor's network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and in a timely manner cover these services out-of-network for the member, for as long as the Contractor is unable to provide them.
- The Contractor must coordinate with out-of-network providers with respect to payment. The Contractor must ensure that cost to the member is no greater than it would be if the services were furnished within the network.
- Except in certain situations, members will be given the choice between at least two providers. Exceptions would involve highly specialized services, which are usually available through only one agency in the geographic area.

Provider credentialing as required in regulation (42 CFR 438.206(b)(6))

- Consistent with requirements in 42 CFR 438.214, and because of historic quality of care behavioral issues in the State, the Contractor shall have written credentialing and recredentialing policies consistent with federal and State regulations for selection and retention of providers, credentialing and re-credentialing and nondiscrimination.
- The Contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the State of Louisiana's credentialing criteria, who agree to the standard contract provisions and who wish to participate.
- The Contractor must demonstrate that its providers are credentialed to the EQR during annual review.

Timely access (42 CFR 438.206(c)(1)(i-vi))

- The Contractor and its providers shall meet management of care standards in section
  4c i, ii, iii for timely access to care and services, taking into account the urgency of need for services.
- The Contractor shall establish mechanisms to ensure that network providers comply with the timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.
- For all members, the Contractor's care manager shall 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

Cultural considerations (42 CFR 438.206(c)(2))
Transportation

- The Contractor shall maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the entity shall consider the following:

  - The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.
  - Annually, the Contractor shall submit documentation to the State to demonstrate, in a format specified by the State, that it:
    - Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service area
- Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area.

Interpreter services
See below.

Coordination and referral to community services
- The Contractor shall annually develop and implement a Cultural Competency Plan with specific goals and measurable outcomes that address:
  - The impact of culture, ethnicity, race, gender, sexual orientation and social class within the service delivery process, the ability of members and families/caretakers to access and use services, and how systems within and across each region operate.
  - The fit and relevance of services and service providers to the communities within each region, and strategies to optimally engage members and their families/caretakers in ways that reflect their culture and experiences.
- The Contractor shall have the following network standards:
  - Have qualified service providers deliver covered behavioral health services, with behavioral health professionals and paraprofessionals who are fluent in speaking the member's primary or preferred language. In cases where the member's primary or preferred language is rarely spoken in the geographic service area, services shall be delivered with the assistance of a qualified interpreter.
  - Respond and deliver services consistent with the person's cultural, linguistic and spiritual heritage and preferences.
  - Have sufficient provider staff available to deliver culturally appropriate services for Latino, African American, Native American and other minority members.
- The Contractor shall respond to individuals with limited English proficiency through the use of bilingual/multi-cultural staff or language assistance services. Bilingual/multi-cultural staff, at a minimum, shall speak English, Vietnamese, Spanish and any other language spoken by at least 5% of the eligible population.
  - The Contractor is required to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the consumer in his/her spoken language and/or access to a phone-based translation service so that someone is readily available to

communicate orally with the consumer in his/her spoken language. The Contractor shall require providers to have staff available to communicate with the consumer in his/her spoken language and/or access to a phone-based translation service so that someone is readily available to communicate orally with the consumer in his/her spoken language.
  - The Contractor shall utilize a language line translation system for callers whose primary language is not English. This service shall be available 24/7/365.
  - The Contractor shall maintain a sufficient number of accessible qualified oral interpreters, bilingual staff and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats.

Assurances of Adequate Capacity 438.207

Documentation and assurances of adequate capacity and services (42 CFR 438.207 (b), (c))

- The Contractor shall submit documentation ensuring adequate capacity and services as specified by the State and, specifically, as follows, but no less frequently than:
  - At the time it enters into a contract with the State
  - At any time there has been a significant change (defined as more than 1% change in the Contractor's network) in the Contractor's operations that would affect adequate capacity and services, including changes in services, benefits, geographic service area or payments, or enrollment of a new population with the Contractor
- Annually, the Contractor shall submit documentation to the State to demonstrate, in a format specified by the State, that it:
  - Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service area
  - Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area

Coordination and Continuity of Care 438.208
Primary care and coordination of health care services for all MCOs (42 CFR 438.208 (a)(b)(1)-(b)(4)) ▪ Care management is the overall system of medical and psychosocial management encompassing, but not limited to, utilization management (UM), care coordination, discharge planning following restrictive levels of care, continuity of care, care transition and QM. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring specialized behavioral health services and linkages to primary medical care services. These activities shall include scheduling assistance, monitoring and follow-up for member(s) requiring specialized behavioral health services. ▪ The care manager shall determine if the individual has a primary care physician (PCP) and, if not, refer the individual to a PCP in the CCN. – Allow each member to choose his or her provider to the extent possible and appropriate. – If the Contractor would otherwise be required to provide, reimburse for or provide coverage of a counseling or referral service, it is not required to do so if the Contractor objects to the service on moral or religious grounds. – If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it shall furnish information about the services it does not cover as follows: – To the State – With its application for a Medicaid contract – Whenever it adopts the policy during the term of the contract – It shall be consistent with the provisions of 42 CFR 438.10 – It shall be provided to potential enrollees before and during enrollment – It shall be provided to enrollees within 90 days after adopting the policy with respect to any particular service ▪ Document the individual's PCP in the care management record or, if none, follow up on the PCP referral as part of the ongoing care management process. This will be the Contractor's procedure for ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. ▪ Document the date of annual well care visits and track to ensure primary care visits are scheduled and kept. ▪ Obtain signature for release of information from the member, or the family/caregiver for children, to coordinate care with the PCP and other health care providers. ▪ If medications are prescribed by the Contractor providers, obtain a list of medications prescribed by PCP and other specialists for a complete and reconciled medication list that is updated every 90 days. ▪ 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 and that network providers, having received such a release, provide timely notification, as necessary, to PCPs of the member's

treatment throughout the time the member receives mental health treatment from the network provider. Special emphasis shall be placed on notifying the member's PCP of the initiation of, or change in, psychotropic medication.

- Coordinate care with the PCP, with the individual's authorization, to promote overall health and wellness.
- Coordinate the services the Contractor furnishes to the member with the services the member receives from any other MCO.
- Share with other MCOs serving the member the results of its identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated.
- To ensure that, in the process of coordinating care, each enrollee's privacy is protected, consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45,
  CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information. Health plans must comply with these requirements if they meet the definition of health plan found at 160.103: group health plan, health insurance issuer, HMO, Medicaid programs, State Children's Health Insurance Plan (SCHIP) program, any other individual or group plan or combination of individual or group plans that provides or pays for the cost of medical care. CMS recommends that Medicaid managed care contracts include a provision that states that the MCO/PIHP/prepaid ambulatory health plan (PAHP), as applicable, is in compliance with the requirements in 45 CFR parts 160 and 164.

Coverage and Authorization of Services 42 CFR 438.210

- The amount, duration and scope of medically-necessary services provided shall be no less than the same services under the FFS program, as defined in the applicable portions of Attachment F, the Louisiana Medicaid State Plan and relevant FFS provider manuals (e.g., outpatient hospital, including emergency rooms, federally qualified health centers (FQHCs) and advanced practice registered nurses (APRNs)). The Contractor shall meet the minimum federal requirements for provision of Medicaid FFS services. The amount, duration and scope of benefits under this Contract shall be no less than the amount, duration and scope for the same services furnished to beneficiaries under FFS Medicaid.
- The Contractor shall use the State Medicaid definition of "medically necessary services" in a manner that is no more restrictive than the State Medicaid program. All services for which a member is eligible, shall, at a minimum, cover:
  - The prevention, diagnosis and treatment of health impairments
  - The ability to achieve age-appropriate growth and development
  - The ability to attain, maintain or regain functional capacity
- The Contractor shall:
  - Have written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization of a member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner
  - Have mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider as 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 is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease
- Provide a mechanism in which a member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance and appeal procedures (i.e., Grievance System) as per 42 CFR §431.201
- Provide for the following decisions and notices: In regards to standard authorization decisions, the Contractor shall provide notice as expeditiously as the enrollee'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: 1) the member or the provider requests extension or 2) the Contractor justifies to DHH, upon request, a need for additional information and how the extension is in the member's best interest

Expedited authorization decisions:

- For cases in which a provider indicates, or the Contractor 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 Contractor shall make an expedited authorization decision and provide notice, as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service.
- The Contractor may extend the three-business-day time period by up to 14 calendar days, if the member requests an extension or if the Contractor justifies to DHH, upon request, a need for additional information and how the extension is in the member's best interest.

The identification of mechanisms the State uses to identify persons with special health care needs to MCOs, PIHPs and PAHPs is included in the Quality Strategy, Section 2.

Notice of Action 438.404, 438.200, 438.228, 438.206

42 CFR 438.228, 431.206(b) and 431.210 State procedures (42 CFR 438.200) Language and format (42 CFR 438.404(a), 42 CFR 438.10(c) and (d))

Notice of action language and format requirements.

- The notice shall be in writing and shall meet the language and format requirements of 42 CFR. §438.10(c) and (d) to ensure ease of understanding.

Notice of adverse action content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)

- Content of notice. The notice shall explain the following:
  - The action the Contractor or its subcontractor has taken or intends to take.
  - The reasons for the action.

- The member's or the provider's right to file an appeal with the Contractor.
- The member's right to request a State Fair Hearing, after the Contractor's appeal process has been exhausted.
- The procedures for exercising the rights specified in this section.
- The circumstances under which expedited resolution is available and how to request it.
- The member's rights 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.

Timeframes for notice of action: (42 CFR 438.404(c)(1))
Termination, suspension or reduction of services.

- The Contractor shall mail the notice within the following timeframes:
  - For termination, suspension or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under 42 CFR. § 431.213 and 431.214.

Timeframes of notice of action (42 CFR 438.404(c)(2), (3), (4), (5) and (6))

- The Contractor shall mail the notice within the following timeframes:
  - For denial of payment, the notice is sent at the time of any action affecting the claim.
  - For standard service authorization decisions that deny or limit services, the notice is sent as expeditiously as the member's health condition requires and within 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 provider requests extension.
    - The Contractor justifies (to OBH upon request) a need for additional information and how the extension is in the member's interest.
    - If the Contractor extends the timeframe in accordance with above extensions, it shall:
      - Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
      - Issue and carry out its determination, as expeditiously as the member's health condition requires, and no later than the date the extension expires.
- For expedited service authorization decisions where a provider indicates, or the Contractor 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 Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service.
- The Contractor may extend the three-business-day time period by up to 14 calendar days if the member requests an extension or if the Contractor justifies (to DHH-Behavioral health upon request) a need for additional information and how the extension is in the member's interest.

- For service authorization decisions not reached within the timeframes specified above, the notice is sent on the date that the timeframes expire.

Untimely service authorization decisions and service authorization requests

- The Contractor shall not create barriers to timely due process. The Contractor shall be subject to sanctions if it is determined by the Department that the Contractor has created barriers to timely due process and/or if 10% or more of grievance decisions appealed to a State Fair Hearing level within a 12-month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include, but not be limited to:
  - Including binding arbitration clauses in Contractor 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

Handling of Grievances and Appeals 438.228(b) and 438.406

General requirements 42 CFR 438.406(a)

The Contractor shall have a grievance system that complies with 42 CFR §438 Subpart F. The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable State and federal laws.

- The Contractor's grievance and appeals procedures, and any changes thereto, shall be approved in writing by DHH prior to their implementation and shall include, at a minimum, the requirements set forth in this document. The Contractor shall refer all Contractor members who are dissatisfied with the Contractor or its subcontractor, in any respect, to the Contractor's designee authorized to review and respond to grievances and appeals and require corrective action. The member must exhaust the Contractor's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

General requirements of the grievance system

- Grievance system. The Contractor shall have a system in place for members that includes a grievance process, an appeal process and access to the State Fair Hearing system once the Contractor’s appeal process has been exhausted.
- Filing requirements:
  - Authority to file. A member may file a grievance and a Contractor level appeal, and may request a State Fair Hearing once the Contractor’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. A network provider may file a grievance or

request a State Fair Hearing on behalf of a member.
- Timing. The member must be allowed 30 calendar days from the date on the Contractor'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.
- Procedures. The member may file a grievance, either orally or in writing, with the Contractor. The member, or a representative acting on their behalf, or the provider may file an appeal, either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.

The process for appeals 42 CFR 438.406(b)

- The Contractor shall not create barriers to timely due process. The Contractor shall be subject to sanctions if it is determined by the Department that the Contractor has created barriers to timely due process and/or if 10% or more of grievance decisions appealed to a State Fair Hearing level within a 12-month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include, but not be limited to:
  - Including binding arbitration clauses in Contractor 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

Handling of grievances and appeals. The grievance and appeal procedures shall be governed by the following requirements:

- General requirements. In handling grievances and appeals, the Contractor shall meet the following requirements:
  - 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.
  - Acknowledge receipt of each grievance and appeal. Send an acknowledgement letter via the US Postal Service to the originator of the appeal or grievance within three business days.
  - Ensure that the individuals who make decisions on grievances and appeals are individuals:
    - Who were not involved in any previous level of review or decisions
    - Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:
      - An appeal of a denial that is based on lack of medical necessity
      - A grievance regarding denial of expedited resolution of an appeal

- A grievance or appeal that involves clinical issues

Special requirements for appeals. The process for appeals shall:

- Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and shall be confirmed in writing, unless the member or the provider requests expedited resolution.
- Provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. (The Contractor shall inform the member of the limited time available for this in the case of expedited resolution.)
- Provide the member and his or her representative 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.
- Include, as parties to the appeal:
  - The member and his or her representative
  - The legal representative of a deceased member's estate

Special requirements for grievances involving quality of care (QOC) concerns.

- The Contractor shall address QOC concerns through the grievance process. This includes investigating, analyzing, tracking, trending, disposing and reporting, including adherence to all relevant DHH-Office of Mental Health critical incident reporting requirements and the following:
  - Conducting follow-up with the member or family/caregiver to determine that immediate behavioral health care needs are met, including follow-up after discharge from inpatient levels of care within 72 hours
  - Referring grievances with QOC issues to the Contractor’s peer review committee, when appropriate
  - Referring or reporting the grievance QOC issue(s) to the appropriate regulatory agency, child or adult protective services and OBH for further research, review or action, when appropriate
  - Notifying OBH and the appropriate regulatory or licensing board or agency when the affiliation of a qualified service provider is suspended or terminated due to QOC concerns

Resolution and notification (42 CFR 438.408(a), (b), (c))

- The Contractor shall dispose of a grievance, resolve each appeal and provide notice, as expeditiously as the member’s health condition requires, within the timeframes established below.

Format and content of resolution notice (42 CFR 438.408(d)(e))

- Grievances. The Contractor shall notify a member of the disposition of a grievance via a letter to the originator of the grievance containing, at a minimum:
  - Sufficient detail to foster an understanding of the QOC resolution
  - A description of how the member’s behavioral health care needs have been met
  - A contact name and telephone number to call for assistance or to express any unresolved concerns
- Appeals. For all appeals, the Contractor shall provide written notice of disposition. For notice of an expedited resolution, the Contractor shall also make reasonable

efforts to provide oral notice.

- Content of notice of appeal resolution. The written notice of the resolution shall include the following:
  - The results of the resolution process and the date it was completed
  - For appeals not resolved wholly in favor of the members:
    - The right to request a State Fair Hearing and how to do so
    - The right to request to receive benefits while the hearing is pending and how to make the request
    - That the member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action
- Format of resolution notice. In addition to written notice, the Contractor shall also make reasonable effort to provide oral notice.

Grievance/Appeal Records and Reports (42 CFR 438.228(b)

- The Contractor shall electronically provide OBH with a monthly report of the grievances/appeals in accordance with the requirements outlined by OBH to include, but not be limited to, member's name and Medicaid number, summary of grievances and appeals, date of filing, current status, resolutions and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.
- The Contractor shall be responsible for promptly forwarding any adverse decisions to OBH for further review/action upon request by OBH or the Contractor member. OBH may submit recommendations to the Contractor regarding the merits or suggested resolution of any grievance/appeal.
- OBH may conduct random reviews to ensure that members are receiving such notices in a timely manner.

Requirements for State Fair Hearings (42 CFR 438.408(f))

- Requirements for State Fair Hearings. DHH shall comply with the requirements of 42 CFR §§431.200(b), 431.220(5) and 42 CFR §§438.414 and 438.10(g)(1). The Contractor shall comply with all requirements as outlined in this Contract and by OBH:
  - Availability. If the member has exhausted the Contractor level appeal procedures, the member may request a State Fair Hearing within 30 days from the date of the Contractor's notice of resolution.
  - Parties. The parties to the State Fair Hearing include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate.
  - Expedited resolution of appeals. General rule: The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.
  - Punitive action. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's

appeal.
- Action following denial of a request for expedited resolution. If the Contractor denies a request for expedited resolution of an appeal, it shall:
  - Transfer the appeal to the timeframe for standard resolution in accordance with this section of the RFP
  - Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days with a written notice
- This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The member may file a grievance in response to this decision.
- Failure to make a timely decision. Appeals shall be resolved no later than above stated timeframes, and all parties shall be informed of the Contractor's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.
- Process. The Contractor is required to follow all standard appeal requirements for expedited requests, except where differences are specifically noted in the requirements for expedited resolution. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.
- The Contractor shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

Information About the Grievance System to Providers and Subcontractors. 438.414

Information (42 CFR 438.414) (438.10 (g))
The Contractor shall provide the information specified at 42 CFR. § 438.10(g)(1) about the grievance system to all providers and Contractors at the time they enter into a contract.

Record Keeping and Reporting Requirements. 438.416

- Recordkeeping and reporting requirements.
  - Reports of grievances and resolutions shall be submitted to DHH. The Contractor shall not modify the grievance procedure without the prior written approval of DHH. At a minimum, grievances and appeals will contain the following information:
    - The name and contact information of the originator of the grievance or appeal
    - A description of the grievance or appeal, including issues, dates and involved parties
    - All steps taken during the investigation and resolution process
    - Corrective action(s) implemented and their effectiveness
    - Evidence of the resolution
    - A copy of the acknowledgement and resolution letters
    - Any referral made by the Contractor to peer review a regulatory agency, a

licensing board or agency or OBH
- Any notification made by the Contractor to OBH or a regulatory or licensing agency or board

Continuation of Benefits While the MCO or SMO Appeal and the State Fair Hearing are Pending. 438.420

Terminology, timely filing and continuation of benefits (42 CFR 438.420(a), (b))

- Continuation of benefits while the Contractor appeals and State Fair Hearing is pending.
  - Terminology:
    - As used in this section, “timely" filing means filing on or before the later of the following:
      - Within 10 days of the Contractor mailing the notice of action
      - The intended effective date of the Contractor's proposed action
- Continuation of benefits. The Contractor shall continue the member's benefits if:
  - The member or the provider files the appeal timely
  - The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
  - The services were ordered by an authorized provider
  - The original period covered by the original authorization has not expired
  - The member requests extension of benefits

Duration of continued or reinstated benefits (42 CFR 438.420(c))

- Duration of continued or reinstated benefits. If, at the member's request, the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits shall be continued until one of following occurs:
  - The member withdraws the appeal
  - Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
  - A State Fair Hearing officer issues a hearing decision adverse to the member
  - The time period or service limits of a previously authorized service has been met

Enrollee responsibility for services furnished (42 CFR 438.420(d))

- If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR § 431.230(b).

Effectuation of Reversed Appeal Resolutions. 438.424

Effectuation when services were not furnished (42 CFR 438.424(a))

Services not furnished while the appeal is pending.

- If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit

or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

Effectuation when services were furnished (42 CFR 438.424(b))
Services furnished while the appeal is pending.

- If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall pay for those services in accordance with this Provider Agreement.

Record Keeping and Reporting Requirements. 438.416

The PIHP must maintain records of grievances and appeals as follows:

- The PIHP shall maintain records that include a copy of the original grievance or appeal, the response and the resolution.
- The PIHP must provide for the retention of the records described above for five years following a final decision or the close of the grievance or appeal. If any litigation, claims negotiation, audit or other action involving the records has been started before the expiration of the five-year period, the records shall be retained until completion of the action and resolution of issues that arise from it or until the end of the regular five-year period, whichever is later.

Continuation of Benefits While the MCO or PIHP Appeal and the State Fair Hearing are Pending. 438.420

Terminology, timely filing and continuation of benefits (42 CFR 438.420(a), (b))

The PIHP must continue the enrollee's benefits if:

- The appeal is filed timely, meaning on or before the later of the following:
  - Within 11 days of the PIHP mailing the notice of action
  - The intended effective date of the PIHP's proposed action
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The authorization period has not expired.
- The enrollee requests extension of benefits.

Duration of continued or reinstated benefits (42 CFR 438.420(c))

If the PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The enrollee withdraws the appeal.
- The enrollee does not request a State Fair Hearing within 11 days from when the PIHP mails an adverse PIHP decision.
- A State Fair Hearing decision adverse to the enrollee is made.
- The authorization expires or authorization service limits are met.

Enrollee responsibility for services furnished (42 CFR 438.420(d))

The PIHP may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the PIHP's action.

Provider Selection

Selection and retention (42 CFR 438.214(a), (b)(2))

- Consistent with requirements in 42 CFR 438.214, and because of historic quality of care behavioral issues in the State, the Contractor shall have written credentialing and recredentialing policies consistent with federal and State regulations for selection and retention of providers, credentialing and re-credentialing and nondiscrimination.
- The Contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the State of Louisiana credentialing criteria, who agree to the standard contract provisions and who wish to participate.
- The Contractor shall conduct credentialing and privileging in accordance with the OBH Services Definitions Manual. When necessary, the Contractor shall utilize processes to expedite temporary (or provisional) credentialing and privileging to maintain network sufficiency or to add specialty providers.
- The Contractor must demonstrate that its providers are credentialed to the EQR during annual review.

Non-discrimination (42 CFR 438.214(c)) (42 CFR 438.12(a))

- The Contractor shall not discriminate against any provider based solely on the provider's type of licensure or certification. In addition, the Contractor shall not discriminate against providers that serve high-risk populations or specialize in treating behavioral health conditions that are costly. This provision does not prohibit the Contractor from limiting the size or scope of its provider networks or establishing procedures to control costs to meet the needs of the members it is required to serve in this Contract.
- The Contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the State of Louisiana credentialing criteria, who agree to the standard contract provisions and who wish to

participate

(42 CFR 438.12(b)(2))

- The Contractor may not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of providers in its network, it must give the effected providers written notice of the reason for its decision. 42 CFR 438.12 (a) of this section may not be construed to:
  - Require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees
  - Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty
  - Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members

(42 CFR 438.12(b)(3))

See above.

Excluded providers (42 CFR 438.214(d))

The Contractor shall not subcontract with providers excluded from participation in federal health care programs, pursuant to Section 1128 or Section 1128(A) of the Social Security Act.

State requirements (42 CFR 438.214(e))

Qualification of providers shall be conducted in accordance with the procedures delineated in the State's Credentialing Policy outlined above.

Confidentiality 438.224

Confidentiality requirements consistent with (42 CFR 438.224)

- Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of OBH, confidentiality rules and facility access procedures.)
- Each enrollee's privacy is protected consistent with the confidentiality requirements in
  45 CFR, parts 160 and 164. 45 CFR, Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.
- Require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456. For medical records and any other health

and enrollment information that identifies a particular enrollee, the Contractor shall establish and implement procedures consistent with confidentiality requirements in 45 CFR, parts 160 and 164.

Enrollment and Disenrollment 438.226

Enrollment and disenrollment (42 CFR 438.226)

- The State, through DHH, shall be responsible for determining the eligibility of an individual for Medicaid-funded services. The State, through OBH, is responsible for all enrollment and disenrollment into the SMO. The State automatically enrolls Medicaid beneficiaries on a mandatory basis into the SMO, for which it has requested a waiver of the requirement of choice of plans. As used in this RFP, a Medicaid enrollee means a Medicaid recipient who is currently enrolled in the Contractor's program. There are no potential enrollees in this program because the State automatically enrolls beneficiaries into the single SMO. State staff conducts the enrollment process. Louisiana is expected to receive an additional waiver of disenrollment of 42 CFR 438.56 under the pending 1915 (b) waiver. The Contractor may not disenroll recipients for any reason. Eligible recipients may not disenroll from the SMO, but the State may disenroll Medicaid recipients whose eligibility changes to a Medicaid coverage group excluded from the SMO or who otherwise lose Medicaid eligibility, consistent with the terms of this Contract and the related waiver, and are not covered under one of the enrolled non-Medicaid coverage groups.
- Enrollees in the State's 1115 Medicaid demonstration may be enrolled in this contract on or after March 1, 2012. Those enrollees will have a different benefit package than other enrollees.

Specific requirements of the Contractor for Medicaid enrollment:

- The Contractor shall accept individuals in the order in which they are enrolled, without restriction.
- The Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services, race, color, gender or national origin.
- The Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, gender or national origin.
- The Contractor shall not request disenrollment of any member for any reason, including requests because of a change in the member's health status or because of the member's utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs.
- The Contractor shall specify the methods by which it will ensure social and rehabilitation services (SRS) that it does not request disenrollment for any reason.
- The Contractor will automatically re-enroll a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less.
- All eligible Medicaid beneficiaries are automatically enrolled by the State into the SMO upon eligibility determination.

Subcontractual Relationships and Delegation 438.230
▪ The Contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the OBH. The Contractor shall not substitute any subcontract without the prior written approval of the OBH. ▪ The Contractor shall oversee and hold subcontracts accountable for any functions and responsibilities that it delegates. The Contractor shall have credentialing and recredentialing policies consistent with federal and state regulations. The Contractor shall evaluate the prospective subcontract's ability to perform the activities to be delegated. ▪ The Contractor is not obligated to contract with any provider unable to meet contractual standards. In addition, the Contractor is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the Contractor and State. The Contractor's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. ▪ The Contractor shall have a written contract that specifies the activities and report responsibilities delegated to the subcontract and provides for revoking delegation, terminating contracts or imposing other sanctions if the subcontract's performance is inadequate. The Contractor shall monitor all subcontracts' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The Contractor shall identify deficiencies or areas for improvement, and the subcontract shall take corrective action. For subcontract(s), before commencing work, the Contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the Contractor will be satisfied by all subcontracts through the following: ▪ The subcontract(s) will provide a written commitment to accept all contract provisions. ▪ The subcontract(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract. ▪ All subcontracts shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

Quality Assessment and Performance Improvement

Measurement and Improvement Performance Standards

Practice Guidelines

Dissemination (42CFR 438.236 (c))

- The Contractor shall adopt, disseminate and apply practice guidelines developed in collaboration with OBH for the CSoC and others the Contractor chooses to adopt for all members, consistent with CMS requirements in 42 CFR 438.236. The Contractor shall disseminate the practice guidelines to qualified service providers and the WAA and, upon request, to members utilizing behavioral health services. The Contractor shall also provide WAA and qualified network providers with technical assistance and other resources to implement the practice guidelines.

Application (42 CFR 438.236(d))

- The Contractor shall utilize medical management criteria and practice guidelines that:
  - Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
  - Consider the needs of members
  - Are adopted in consultation with contracted health care professionals
  - Are reviewed and updated periodically as appropriate, but at least annually:
    - As part of the implementation planning for this Contract, the Contractor shall collaborate with OBH and the CSoC Governance on the development of appropriate practice guidelines.
    - The Contractor shall use practice guidelines as a basis for decisions regarding UM, member education, provider education, coverage of services and other areas to which practice guidelines apply. The Contractor shall implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the Contractor shall monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures.
    - Using information acquired through quality and UM activities, the Contractor shall recommend to OBH each year the 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.

Quality Assessment and Performance Improvement Program

Requirements (42 CFR 438.240(b))

- The Contractor shall operate a comprehensive QM program that includes constant evaluation of the Contractor's operations and the specialized behavioral health systems of care under its management, including the WAA. The Louisiana quality improvement strategy (QIS) (incorporated herein by reference) shall be included in the Contractor's overall QM plan. At a minimum, the Contractor will utilize the QIS to detect both under utilization and over utilization of services and to assess the quality and appropriateness of care furnished to enrollees, including enrollees with special health care needs.
- The Contractor shall maintain a sufficient number of qualified QM personnel to implement the requirements of this Contract, including reviewing performance standards, measuring

treatment outcomes and ensuring timely access to care.

- The Contractor shall provide a mechanism for the input and participation of members, families/caretakers, the CSoC Governance, OBH and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
- The Contractor shall develop, implement and maintain a comprehensive program for QAPI, consistent with federal requirements at 42 CFR 438.240 and with the UM program required by CMS for OBH's overall Medicaid program, as described in 42 CFR 456.

- The QAPI program shall include a system of performance indicators and member/family outcome measures that address different audiences and purposes. The Contractor shall implement and maintain a formal outcomes assessment process that is standardized, reliable and valid in accordance with industry standards.
- The Contractor shall report, from the start of the Contract (at a minimum), on the goals, objectives and measures identified in the DHH CMS QIS.
- On an annual basis, the Contractor shall ensure and report to the State its performance, using standard measures required by the State and outlined in the QIS.
- The Contractor shall develop and implement outcome measures with input from, and the participation of, CSoC Governance, OBH, members, family members and other stakeholders.
- The Contractor shall report to OBH the results and findings of its outcome measures compared to expected results and findings, including performance improvement efforts and activities planned/taken to improve outcomes.

- The Contractors QAPI program shall meet the following requirements:
  - Include QM processes to assess, measure and improve the QOC provided to members in accordance with:
    - All QM requirements identified in the contract
    - The DHH CMS QIS
    - All State and federal regulatory requirements
    - Other applicable documents incorporated by reference
  - Identify and resolve systems' issues consistent with a continuous QI approach.
  - Disseminate information to the OBH, the CSoC Governance and its participating agencies, members, providers and key stakeholders, including families/caregivers.
  - Solicit feedback and recommendations from key stakeholders, subcontracts, members and families/caregivers, and use the feedback and recommendations to improve the QOC and system performance.
  - Measure and enforce adherence with the goals and principles of the CSoC and OBH through the following strategies, at a minimum:
    - Methods and processes that include in-depth chart reviews and interviews with key persons in the member's life
    - Use of findings to improve practices at the subcontract and Contractor levels
    - Timely reporting of findings and improvement actions taken and their effectiveness
    - Dissemination of findings and improvement actions taken, and their effectiveness to key stakeholders, committees, members and families/caregivers and posting on the Contractor's website.

Quality and appropriateness of care (42 CFR 438.240(b)(4)

The Contractor shall operate a comprehensive QM program that includes constant evaluation of the Contractor's operations and the specialized behavioral health systems of care under its management, including the WAA. The Louisiana QIS (incorporated herein by reference) shall be included in the Contractor's overall QM plan. At a minimum, the Contractor will utilize the QIS to detect both under utilization and over utilization of services and to assess the quality and appropriateness of care furnished to enrollees, including individuals with special health care needs.

Under utilization and over utilization (42 CFR 438.240(b)(4)

- At a minimum, the Contractor will utilize the QIS to detect both under utilization and over utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Performance measurement requirements (42 CFR 438.240(b) and 42 CFR 438.240(c))

- The QAPI program shall include a system of performance indicators and member/family outcome measures that address different audiences and purposes. The Contractor shall implement and maintain a formal outcomes assessment process that is standardized, reliable and valid in accordance with industry standards.
- The Contractor shall report, from the start of the Contract (at a minimum), on the goals, objectives and measures identified in the DHH CMS QIS.
- On an annual basis, the Contractor shall ensure and report to the State its performance, using standard measures required by the State and outlined in the QIS.
- CMS, in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by states in their contracts with Contractors.

Performance improvement project requirements (42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1)

The Contractor shall conduct at least two performance improvement projects outlined in the QIS that are designed to achieve, through ongoing measurements 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. The Contractor shall report the status and results of each project to the State as requested. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. The performance improvement projects shall involve the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

Reporting and outcome (42 CFR 438.340(d)(2))

The Contractor shall collect data and conduct data analysis with the goal of improving QOC

within the behavioral health system. The Contractor's information system will support the QAPI process by collecting, analyzing, integrating and reporting data necessary to the State's QIS. All collected data shall be available to the State and upon request to CMS. The system shall provide information on areas, including, but not limited to, utilization, grievances and appeals and disenrollment for other than loss of Medicaid eligibility. The system shall also collect data on enrollee and provider characteristics as specified by the State and on services furnished to enrollees through an encounter data system. The system shall ensure that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic and consistency
- Collecting service information in standardized formats to the extent feasible and appropriate

The Contractor shall participate in developing, implementing and reporting on performance measures and topics for PIPs required by other state or federal agencies, including performance improvement protocols or other measures, as directed by OBH.

The Contractor shall report to OBH the National Outcome Measures (NOMS) required for the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants and any federal discretionary grants in which the OBH may participate.

The Contractor shall report performance data to OBH, BHSF, DCFS, OJJ, OCDD and DOE in formats approved, in advance, by OBH.

State requirements for PIHP evaluation of QAPI (42 CFR 438.240(e)(2))

- On an annual basis, the Contractor shall ensure and report to the State its performance, using standard measures required by the State and outlined in the QIS.
- The Contractor shall have, in effect, a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.
- The Contractor shall participate in developing, implementing and reporting on performance measures and topics for PIPs required by other state or federal agencies, including performance improvement protocols or other measures, as directed by OBH.

Health Information Systems

State requirements for health information systems (42CFR 438.242)

1. Information management, analysis and reporting are essential to the effective and efficient operation of the Contractor and to fulfilling State and federal reporting requirements for Medicaid, State General Fund and grants, including the mental health and substance abuse federal block grants. The Contractor's information system shall support the following key functions:
   a. Twenty-four (24) hour, seven (7) days a week toll-free telephone access line user and technical support
   b. Member services (including eligibility for all programs operated under the SMO)

c. Management of care
d. Quality management
e. Grievances and appeals
f. Provider network management
g. Member rights and responsibilities
h. Financial reporting claims payment for non-capitated services
i. Encounter tracking and submissions for capitated services
j. Implementation planning
k. Business continuity, disaster recovery and emergency preparedness
l. Performance measurement and accountability
m. State and federal reporting requirements described below
n. Secure electronic data interchange, as needed, to accomplish the above functions, operation of the OBH data warehouse, and State access to client-level data for DCFS, DOE and OJJ

2. The Contractor shall have the capacity to collect, analyze, electronically and securely transfer, report and utilize data from multiple service provider sources, and have the capacity to adapt and upgrade these functions, as necessary, with future changes to the service and administrative operations of the CSoC and the behavioral health services program for children and adults.

3. The Contractor shall have the ability to accept and analyze pharmacy data from DHH and report on individual member and aggregate pharmacy utilization data and provider prescribing practices, as well as other similar reports on member pharmacy utilization for quality management purposes.

4. The Contractor shall have the capacity to monitor and analyze utilization data for individuals not enrolled as members of the SMO, but receive their behavioral health services from other sources (e.g., federally qualified health center/rural health clinic, CCN). DHH will provide utilization data to the Contractor. The Contractor shall work closely with OBH and BHSF to identify costs, utilization trends and QOC issues.

5. The Contractor shall provide a comprehensive, integrated, secure internet-based behavioral health information management system (IMS) which supports: 1) the functions of the public behavioral health system; 2) OBH as the operating agency of the CSoC; 3) interface with the other child-serving agencies financing the CSoC (DCFS, DOE, OJJ); 4) the Louisiana Behavioral Health Services Medicaid program; 5) the CSoC and 6) all subcontracting providers. The Proposer shall work closely with DHH, OBH, BHSF and stakeholders on an ongoing basis to ensure implementation, operation and maintenance of this critical information resource.
   a. The IMS shall provide the following capacity for electronic data collection, analysis, transfer and reporting of data at the client (not just aggregate) level and will provide the required data to the MMIS for Medicaid claims processing, reporting and auditing.
   b. The IMS shall support claims processing and administration, membership management, provider network management, including provider profiling, outcomes and quality of

care information, care management, utilization management, grievances and appeals, and member services. The Contractor shall utilize current State and federal standards and procedures (e.g., HL7; HIPAA; CMS; CPT; ICD-10) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes. The Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

c. The scope of coverage of the IMS will be for all programs and services provided through the Contractor.
d. The data content will include, but may not be limited to, the following data sets: client data (socio-demographic and contact information, unique client ID), assessment data (including diagnoses in current Diagnostic and Statistical Manual of Mental Disorders format, level of functioning scores), service encounter data (e.g., date, type, duration, recipient, provider), episode data (e.g., service program, unique episode ID, date of first contact, date of admission, date of last contact, date of discharge), programmatic data (e.g., service population and eligibility, payer source, fee schedules), individual claims data and provider data (e.g., provider agency, name, unique provider ID, discipline). The technical specifications of these data will be in keeping with State and federal standards (i.e., SAMHSA) for data content.
e. The Contractor will be expected to update at least bi-weekly and transfer this dataset in a format and file structure (including requisite documentation) required by OBH and the process and procedures in keeping with the changing reporting requirements of the State and federal government and local programs. The Contractor will be expected to provide OBH current documentation of the data set, process and procedures.
f. The Contractor shall be responsible for maintaining standardized data collection process and procedures and provide training and support of all provider staff.
g. The Contractor shall perform data quality management, in conjunction with DHH -OBH and the State agencies, in order to demonstrate that the data are accurate, appropriate, complete and reported timely across all program units.

6. The Contractor shall maintain disaster recovery and business continuity of this system, as well as the provisions for the State to have continued access to and use of these data in the event of a separation of service with the contracted Contractor.

7. The Contractor will make all collected data available to the State and upon request to CMS.

Information Requirements

Enrollee information as required by CFR 438.10 (42 CFR 438.218)

1. New members receive an enrollment packet from the Contractor explaining the program. The informational packet is mailed to all new members upon determination of enrollment. The informational packet includes a handbook with information regarding client rights and responsibilities and a provider directory.

2. At a minimum, the member handbook shall include the following materials:
   a. The principles and goals of the CSoC and the Behavioral Health Services Program, including distinct information for eligible children/youth and their families/caregivers and adults.
   b. Where and how to access behavioral health services, provider information (including

emergency or crisis services), a description of covered behavioral health services and key CSoC information.

c. Family/caregiver's role in the assessment, treatment and support for individuals with an emphasis on promoting engagement, resilience and the strengths of individuals and families.
d. Generic information on the treatment of behavioral health conditions and the principles of family, child, youth and young adult's engagement; resilience; strength-based and evidence-based practice and best/proven practices.
e. Generic information on the treatment of behavioral health conditions and the principles of adult, peer and family engagement and recovery, and strength-based and evidence-based practices.
f. Any limitations involving families/caregivers or providing information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment.
g. The Contractor's member service telephone number.
h. How to identify and contact the WAA and the FSO.
i. How to change providers.
j. Oral interpretation is available for any language, and written document interpretation is available in all prevalent languages (English, Spanish, and Vietnamese), and how to access these services.
k. Copy of the member Bill of Rights, as specified in 42 CFR § 438.100.
l. Information regarding advance directives, including:
   (i) Member rights under the law of the State
   (ii) The Contractors' policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience
   (iii) That complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency
m. Names, locations, telephone numbers of and non-English languages spoken by current contracted providers in the member's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on PCPs, specialists and hospitals. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained.
n. Any restrictions on the member's freedom of choice among network providers.
o. Information on grievance and fair hearing procedures and, for members, the information specified in § 438.10(g)(1).
p. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled.
q. Procedures for obtaining benefits, including authorization requirements.
r. The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers.
s. The extent to which, and how, after-hours and emergency coverage are provided, including:
   (i) What constitutes emergency medical condition, emergency services and post stabilization services, with reference to the definitions in § 438.114(a)
   (ii) The fact that prior authorization is not required for emergency services

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent
(iv) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the Contract
(v) The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care

t. The post stabilization care services rules consistent with this contract.
u. Policy on referrals for specialty care and for other benefits not furnished by the member's PCP.
v. Cost sharing, if any.
w. How and where to access any benefits that are available under Medicaid for Medicaid eligibles but are not covered under the contract, including any cost sharing and how transportation is provided. For a counseling or referral service that the Contractor does not cover, because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The State shall provide information on how and where to obtain the service.
x. Grievance, appeal and fair hearing procedures and timeframes, in a State-developed or State-approved description that shall include the following:
(i) For State Fair Hearing:
- The right to a hearing
- The method for obtaining a hearing
- The rules that govern representation at the hearing

(ii) The right to file grievances and appeals.
(iii) The requirements and timeframes for filing a grievance or appeal.
(iv) The availability of assistance in the filing process.
(v) The toll-free numbers that the member can use to file a grievance or an appeal by phone.
(vi) The fact that, when requested by the member:
- Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing.
- The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

y. Annual notification to all Medicaid members of their disenrollment rights. Note: There are no disenrollment rights under the Louisiana contract.
z. Additional information that is available upon request, including the following:
(i) Information on the structure and operation of the MCO or PIHP.
(ii) Physician incentive plans as set forth in 438.6(h) of this chapter.
(iii) The Contractor shall distribute the member handbook to each new member or his/her family/caregiver within 10 days of being registered with the Contractor or first receiving a covered behavioral health service, whichever is earlier. Unless otherwise instructed by OBH, the Contractor shall distribute, in sufficient quantities, the member handbook to WAA, FSOs and other CSoC system partners at least 30 days prior to the contract start date and when requested. The Contractor shall also distribute the member handbook to key providers and other sites, as designated by OBH, to assist with distributing materials to adult

members.

(iv) The Contractor shall review the member handbook at least annually and distribute an updated version to each member or his/her family/caregiver, WAA, FSO and other CSoC partners, and others designated by OBH, on or before October 1 of each year. The Contractor shall update the member handbook and submit it to OBH within 30 days, with any changes determined by OBH in the Behavioral Health Services Program, including the CSoC. If there are no changes at the annual update, then the Contractor shall notify members of the right to request information listed, at least once a year. If the Contractor makes changes to the member Handbook, at a time other than the annual update, the Contractor shall distribute the revised version on a timely basis via regular US Postal Service mail to each member or his/her family/caregiver. Documentation of the handbook's distribution shall be included in the care management record.

3. The Contractor shall provide to members, their families/caregivers and/or providers any of the following:
   a. Notices of Action and Notices of Decision, which shall be delivered in compliance with the language, timeframe and content requirements of federal and State law and this contract.
   b. When the Contractor terminates a contract, provider agreement or suspends or terminates referrals to a qualified service provider, the Contractor shall deliver written notice of termination within 15 days of the termination notice to OBH and to each child, youth and family/caregiver that is currently receiving or has received behavioral health services within the last 180 days from the terminated provider.
   c. Newsletters, policy advice and any other materials that require distribution, as negotiated between the Contractor and OBH.
   d. Other than the member handbook, which shall be provided to all new members upon enrollment and upon request, the Contractor shall timely and accurately disseminate and communicate information required by OBH, subject to the terms of the final Contract. The Contractor shall disseminate information prepared by the federal government, OBH or other State agencies to members or their families/caregivers, subject to the terms of the final Contract.

4. The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures.

5. The Contractor shall furnish members with both verbal and written information about the nature and extent of their rights and responsibilities as a member of the Contractor.

Monitoring Mechanisms – State Monitoring and Evaluation

As required by CFR 438.204(b) (3), Louisiana regularly monitors and evaluates the SMO's compliance with the standards. Ongoing progress reports are submitted by the SMO to IMT for review and evaluation. The scope of this review includes seeking out evidence of ongoing improvement efforts and resulting outcomes. The IMT will provide

feedback to the SMO for successful progress and/or results; however, for results reflecting general non-compliance or substandard performance, interventions will be provided to SMO with timely re-evaluation processes identified. The IMT also reports results of improvement and/or compliance updates to the OBH. The OBH evaluates and provides feedback for areas of success and seeks to identify opportunities for improvement. If interventions are suggested, re-measurement occurs in the appropriate period following implementation.

1915(c) Waiver Monitoring

Louisiana will create systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver participants and that there are effective systems in place to monitor participant health and welfare.

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes and identifies opportunities for improvement. The 1915(c) portion of the Quality Improvement Strategy spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances
- The *remediation* activities that will be followed to correct individual problems identified in the implementation of each of the assurances

The following are: (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting, assessing and prioritizing improving system corrections and improvements and (3) the processes the State will follow to continuously *assess the effectiveness of the QIS* and revise it, as necessary and appropriate.

The Louisiana CSoC SED 1915(c) Waiver operates under the umbrella of a 1915(b) waiver, and both State Plan behavioral health services and CSoC SED waiver services are delivered through a SMO (the SMO) under the terms of a non-risk contract for children. Each waiver type has distinct requirements for quality improvement that are based on federal laws and regulations and are meant to ensure that the goals and intent of the respective waivers are met. During the initial waiver period, quality improvement programs and activities for each waiver will be developed and implemented separately. The SMO reports on performance measures and performance

improvement projects, and an EQR contract will be implemented in compliance with managed care regulations and 1915(b) Waiver requirements. Quality improvement activities for the Louisiana CSoC SED Waiver during the initial waiver period include oversight of the SMO's implementation of processes and procedures to address 1915(c) Waiver assurances, wraparound facilitator, oversight of plan implementation and service delivery and record reviews to identify any issues related to meeting assurances. As the services and populations covered by both waivers are interrelated, and the infrastructure and processes for SMO oversight are now in place, the goal during the upcoming waiver period is to better integrate quality improvement activities for all SMO Medicaid services and to focus on quality improvement. At the same time, it will be necessary to ensure that the specific quality improvement requirements of each waiver type continue to be met.

As stated above, performance measure reporting related mainly to state plan behavioral health services through the SMO will be implemented. The 1915(c) Waiver application contains 34 performance measures specific to the CSoC SED Waiver, which will be implemented and reported to the State through similar processes. The SMO will also ensure that its reporting on grievances and appeals identifies those made specifically by, or on behalf of, Louisiana CSoC SED Waiver participants/applicants.

Quarterly quality improvement meetings with the BHSF, the OBH and the SMO will occur after implementation of the waiver program. The meetings will focus a great deal on implementation of the overall concurrent waiver program and activities specific to Medicaid managed care, including reporting requirements, refining of reports and implementation of EQR activities. This setting provides an excellent backdrop for operationalizing the Louisiana CSoC SED performance measures and moving to the next level of trending, analyzing and setting benchmarks for all services delivered through the SMO.

The IMT includes the SMO in its meetings and conducts annual onsite reviews of SMO's operations in conjunction with the EQR. IMT activities will focus on quality improvement, as well as implementation, with focus in both clinical and non-clinical areas.

The State and the SMO will implement corrective action plans based on specific monitoring activities (such as the annual EQR onsite review). Appendix A of the application describes several discovery activities that the State Medicaid Agency will conduct in exercising its administrative authority over the waiver. All of these activities, including analysis of performance measure reporting, findings from IMT and external reviews, analysis of grievances and appeals reports record reviews by the SMO and review of provider network for adequacy and choice will be the basis for an ongoing corrective action/quality improvement plan. The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress and target dates for completion. The areas for improvement will be prioritized and monitored on a day-to-day basis by the OBH waiver team and the OBH behavioral

health section. Progress, issues and concerns will be presented to the IMT, which will serve as an advisory committee for the plan.

Through tracking and trending of performance reporting and findings from other oversight activities, the OBH and the SMO expect to be able to identify any provider-specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. As examples, with trending and tracking of complaints: a specific provider might be identified who needs additional training or even termination from the network; recurring and excessive delays in implementing service plans might result in changes in internal assessment/authorization processes and, as a final example, inconsistencies identified in level of care determinations could result in additional training to ensure that staff have the same understanding of level of care criteria.

Progress on the corrective action/quality improvement plan will be presented to the IMT for comments and guidance. All Louisiana CSoC SED related monitoring will be summarized and presented to CMS annually through the 372 report process and as requested.

The effectiveness of system design changes – for example, a revised process to initiate the delivery of services more promptly – will be evident through ongoing monitoring activities using the same performance measures. Once performance measures are implemented and the SMO has an initial baseline year of service experience, the State and the SMO will jointly develop benchmark priorities. The OBH, quality management staff and the SMO will work jointly through the quarterly quality improvement meetings to assess system changes and begin developing benchmarks. The IMT will serve in an advisory capacity.

The IMT monitors availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special healthcare needs, coverage and authorization of services, emergency and post-stabilization services, enrollment and disenrollment, grievance systems, health information systems, compliance with contract, and State and federal Medicaid requirements.

The quality improvement strategy for the 1915(c) waiver is incorporated in the managed care quality strategy, as required by 42 CFR 438.202. The quality strategy is reviewed by the quality staff of the OBH through an ongoing process that incorporates input from a multitude of sources, including external stakeholders. The effectiveness of the quality strategy is reviewed on an annual basis and revised based upon analysis of results by the quality management staff in the OBH and the IMT. The quality strategy may be reviewed more frequently, if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed that is compatible with the overall quality strategy. The development process begins with an assessment of the accomplishments of the prior year's quality plan, the EQR technical

report and incorporates input from committees and other established quality forums that include governmental agencies, providers, the SMO, consumers and advocates determining areas of focus for quality activities, such as quality improvement measures, improvement projects and performance indicators.

1915(c) Waiver Assurances and Other Federal Requirements

The State has made the following assurances and sub-assurances to the federal government through the approved 1915(c) Waiver. As part of the assurances and sub-assurances, OBH has agreed to monitor 37 performance measures and report on those measures to CMS in the following manner:

Level of Care Assurances

On a continuous basis, with reports due monthly, OBH will review the SMO's documentation for remediation of identified issues resulting from the LOC assurance monitoring, ensuring that the SMO has performed the required monitoring. The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with the OBH. The OBH may require a corrective action plan for the problems identified. The OBH monitors the corrective action plan with the assistance of IMT. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized. This data is reported to the State Medicaid Agency (BHSF) on a monthly basis at the IMT meeting.

Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of children/youths that were determined to meet LOC requirements prior to receiving waiver services.	Data source: Prior Authorization Reports to the OBH from the SMO Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 100% review Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

Sub-assurance: The LOC of enrolled participants are re-evaluated at least annually or as specified in the approved waiver.

	Performance Measure	Methods
Performance measure #2	Number and/or percent of children/youths who receive their annual LOC evaluation within twelve months of the previous LOC evaluation.	Data source: Record reviews, onsite Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% confidence interval (CI) at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

	Performance Measure	Methods
Performance measure #3	Number and/or percent of children/youths initial LOC determination forms/instruments that were completed as required in the approved waiver.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #4	Number and/or percent of LOC determinations made by a qualified evaluator.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

	Performance Measure	Methods
Performance measure #5	Number and/or percent of children's/youth's semi-annual LOC determinations where level of care criteria was applied correctly.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Semi-annually Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Semi-annually

Participant-Centered Planning and Service Delivery Assurances

On a continuous basis, with reports due monthly, OBH monitors SMO performance data in remediating situations that may arise. The performance data is tracked and trended continuously. Any score below a 100% requires the WAA to submit to the SMO a corrective action plan (formal response). This data is reported to OBH on a monthly basis at the IMT meeting. Potential remediation could include a formal response from the wraparound agency, provider education, a referral for focused review of the WAA by the SMO or recoupment of paid claims. If future changes are required of Louisiana's process due to changes in the State requirements, it is anticipated that the OBH will amend the SMO contract to account for timelines, strategies and responsible parties.

Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of children/youths 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).	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

	Performance Measure	Methods
Performance measure #2	Number and/or percent of children/youths reviewed whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	Data source: Record reviews, onsite Data collection responsible party: Operating agency Frequency of data collection: Quarterly Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Quarterly
Performance measure #3	Number and/or percent of plans of care that address children's/youth's goals as indicated in the assessment(s).	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

	Performance Measure	Methods
Performance measure #4	Number and/or percent of children's/youths' plans of care that include the children's/youth's and/or parent's/caregiver's signature, as specified in the approved waiver.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative Sample, 95% CI at each Wraparound Agency Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

	Performance Measure	Methods
Performance measure #5	Number and/or percent of children's/youths' plans of care that were developed by a child and family team.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #6	The State requires the SMO to report results of performance measures related to the service plan to the OBH and the IMT and requires corrective action, as appropriate. Corrective action is monitored, at minimum, quarterly by OBH and the IMT.	Data source: SMO reports on service plan performance measures Data collection responsible party: SMO Frequency of data collection: Quarterly, with semi-annual performance measure reporting by PIHP Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Quarterly, with semi-annual performance measure reporting by PIHP

Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs

	Performance Measure	Methods
Performance measure #7	Number and/or percent of children/youths whose plans of care were reviewed within 90 days of the last semi-annual update.	Data source: SMO database Data collection responsible party: SMO Frequency of data collection: Ongoing Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #7a	Number and/or percent of children/youths whose plans of care were updated within 180 days of last semi-annual update.	Data source: SMO database Data collection responsible party: SMO Frequency of data collection: Ongoing Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing

	Performance Measure	Methods
Performance measure #8	Number and/or percent of children/youths whose plans of care were updated when warranted by changes in the child/youth's needs.	Data source: Record reviews, onsite Data collection responsible party: SMO Frequency of data collection: Quarterly Sampling: 100% review Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Annually

Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

	Performance Measure	Methods
Performance measure #9	Number and/or percent of children/youths who received services in the type, amount, duration and frequency specified in the plan of care.	Data source: Corporate Compliance Reports to the operating agency from the SMO Data collection responsible party: SMO Frequency of data collection: Quarterly Sampling: Random (RAND) sampling methodology recommended by the Office of the Inspector General (OIG) Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #10	Proportion of new waiver children/youths who are receiving services, according to their PCP within 45 days of PCP approval.	Data source: Person Centered Plan Record Reviews Financial records Data collection responsible party: SMO Frequency of data collection: Quarterly Sampling: Representative sample, 95% CI Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Semi-annually

Sub-assurance: Participants are afforded choice between waiver services and institutional care; and between/among waiver services and providers.

	Performance Measure	Methods
Performance measure #11	Number and/or percent of children/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #12	Proportion of children/youth reporting their wraparound facilitator helps them to know what waiver services are available.	Data source: Record reviews, onsite Data collection responsible party: SMO Frequency of data collection: Quarterly Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Annually
Performance measure #13	Number and/or percent of children/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each care management entity Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing

Qualified Providers Assurances

On an annual basis, OBH monitors qualified providers in remediating situations that may arise. When the SMO or the OBH identify a provider that does not meet licensing and/or training requirements, the State SMO will disenroll the provider until requirements are met. This will be documented by reviewing reports from the training contractor and the SMO. The SMO will address and correct problems identified on a case-by-case basis and include the information in the report to the OBH and the IMT. The OBH may require a corrective action plan if the problems identified appear to

require a change in the SMO processes for making accurate and timely decisions regarding level of care. The OBH monitors the corrective action plan with the assistance of the IMT. Any provider issues that affect the health and safety of waiver children/youths are reported to OBH immediately.

Sub-assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of waiver providers providing waiver services initially meeting licensure, training or certification requirements prior to furnishing waiver services.	Data source: SMO credentialing Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #2	Number and/or percent of waiver providers providing waiver services continuously meeting licensure, training and certification requirements while furnishing waiver services.	Data source: SMO credentialing Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #3	Number and/or percent of providers providing waiver services that have an active agreement with the SMO.	Data source: The OBH contracts with a SMO to enroll qualified providers and pay claims Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 100% review Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing

Sub-assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

	Performance Measure	Methods
Performance measure #4	Number and/or percent of non-licensed/non-certified providers of waiver services that meet training requirements.	Data source: Training verification records Data collection responsible party: Training contractor Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Monthly

Sub-assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

	Performance Measure	Methods
Performance measure #5	Number and/or percent of provider trainings operated by the OBH.	Data source: Training verification records Data collection responsible party: Training contractor Frequency of data collection: Quarterly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Quarterly
Performance measure #6	Number and/or percent of active providers (by provider type) meeting ongoing training requirements.	Data source: Training verification records Data collection responsible party: SMO Frequency of data collection: Annually Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Annually

Participant Safeguards Assurances

The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with the OBH. The OBH may require a corrective action plan for the problems identified. The OBH monitors the corrective action plan with the assistance of the IMT. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized. This data is reported to the State Medicaid Agency (BHSF) on a monthly basis at the IMT meeting.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of reports related to the abuse, neglect or exploitation of children/youths, where an investigation was initiated within established timeframes.	Data source: OBH performance monitoring Data collection responsible party: Operating Agency Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Monthly
Performance measure #2	Number and/or percent of children/youths who received information on how to report the suspected abuse, neglect or exploitation of children.	Data source: OBH performance monitoring Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #3	Number and/or percent of children/youths who received information regarding their rights to a State Fair Hearing via the Notice of Action form.	Data source: Record reviews, onsite Data collection responsible party: SMO and the operating agency Frequency of data collection: Continuously and ongoing Sampling: Representative sample, 95% CI at each WAA Data aggregation responsible party: SMO and the operating agency Frequency of data aggregation and analysis: Continuously and ongoing
Performance measure #4	Number and/or percent of grievances filed by children/youths that were resolved within 14 calendar days according to approved waiver guidelines.	Data source: Record reviews, onsite Data collection responsible party: SMO Frequency of data collection: Weekly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Weekly
Performance measure #5	Number and/or percent of allegations of abuse, neglect or	Data source: OBH abuse, neglect or exploitation database

	Performance Measure	Methods
	exploitation investigated that were later substantiated.	Data collection responsible party: Operating Agency Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Monthly

Waiver Administration and Operation Assurances

On a monthly basis, OBH monitors SMO performance data in remediating situations that may arise. The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with OBH. OBH may require a corrective action plan for the problems identified. OBH monitors the corrective action plan with the assistance of the IMT. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized.

The SMO, in partnership with the OBH, request, approve and assure implementation of provider corrective action planning (and formal responses) and/or technical assistance to address non-compliance with waiver performance standards as detected through onsite SED chart reviews at each provider. The provider is notified verbally of deficiencies and/or non-compliance in a closing conference after each provider SED review visit. The provider is then notified by the SMO through certified mail of areas of non-compliance and the provider's appeal rights.

Provider data is compiled, trended, reviewed and disseminated to each provider through the SED review findings letter. The SMO reviews annual data trending which identifies provider-specific performance levels related to statewide performance standards and statewide averages. Corrective action plan requests (formal responses), technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced. The SMO reports to OBH and BHSF at the monthly IMT team meeting.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of aggregated performance measure reports generated by the operating agency and reviewed by the State Medicaid Agency that contain discovery, remediation and system improvement for ongoing compliance of the assurances.	Data source: Reports to State Medicaid Agency on delegated administrative functions Data collection responsible party: Operating Agency Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency

	Performance Measure	Methods
		Frequency of data aggregation and analysis: Monthly
Performance measure #2	Number and/or percent of waiver amendments, renewals and financial reports approved by the State Medicaid Agency (BHSF) prior to implementation by the operating agency (OBH).	Data source: Reports to State Medicaid Agency on delegated administrative functions Data collection responsible party: Operating Agency Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Monthly
Performance measure #3	Number and/or percent of waiver concepts and policies requiring MMIS programming approved by the State Medicaid Agency prior to the development of a formal implementation plan by the operating agency.	Data source: Reports to State Medicaid Agency on delegated administrative functions Data collection responsible party: Operating Agency Frequency of data collection: Monthly Sampling: 100% review Data aggregation responsible party: Operating Agency Frequency of data aggregation and analysis: Monthly

Financial Accountability

The OBH reviews all proposed recoupment's. The OBH makes recommendations regarding the need for technical assistance and potential formal responses. The OBH maintains access to the SMO prior authorization data system and conducts periodic reviews of the current prior authorization activity. The OBH's access to the prior authorization data system allows for the OBH to generate reports to facilitate this review.

	Performance Measure	Methods
Performance measure #1	Number and/or percent of providers that have payment recouped for waiver services provided without supporting documentation.	Data source: Routine Medicaid claims verification audits Data collection responsible party: SMO Frequency of data collection: Continuously and ongoing Sampling: 90% CI at each WAA Data aggregation responsible party: SMO Frequency of data aggregation and analysis: Continuously and ongoing

	Performance Measure	Methods
Performance measure #2	Number and/or percent of claims verified through the SMO's compliance audit to have paid in accordance with the children/youth's waiver service plan.	Data source: SMO's compliance report Data collection responsible party: SMO Frequency of data collection: Quarterly Sampling: RAND sampling methodology recommended by OIG Data aggregation responsible party: SMO and operating agency Frequency of data aggregation and analysis: Continuously and ongoing

1915(i) State Plan Monitoring

The following tables present the compliance assurance strategies for the 1915(i) State Plan Amendment (SPA):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
The processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine participant if the needs-based criteria are met.	1. The number and/or percent of adults that were determined to meet level of need (LON) requirements prior to receiving 1915(i) services. 2. The number and/or percent of adults who receive their annual LON evaluation within twelve months of the previous LON evaluation. 3. The number and/or percent of adults' initial LON determination forms/instruments that were completed, as required in the approved SPA.	1. Prior authorization reports to the OBH; 100% review. 2. 2., 3., 4., 5. Record review, onsite; less than a 100% sample with a 95% confidence level.	1. SMO collects and generates; OBH and SMO aggregate and analyze. 2. 2., 3., 4., 5., SMO collects and generates; OBH and SMO aggregate and analyze.	1., 2., 3., 4., Continuously and ongoing 5. Semi-annually	OBH	Continuously and ongoing.

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	4. The number and/or percent of LON determinations made by a qualified evaluator. 5. The number and/or percent of adults' annual determinations, where level of care criteria was applied correctly.					
Treatment plans addressed assessed needs of 1915(i) participants, are updated annually and document choice of services and	1. Number and/or percent of participants 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). 2. Number and/or percent of participants reviewed	1., 2., 3., 4., 5. Record reviews, onsite; less than a 100% sample of case managers with a 95% confidence level. 6. SMO reports on treatment	1., 2., 3., 4., 5., OBH and SMO collect, generate, aggregate and analyze. 6. OBH and SMO collect, generate, aggregate and analyze. 7., 8. SMO collects	1. Continuously and ongoing 2. Quarterly 3., 4., 5., Continuously and ongoing 6. Quarterly for corrective action plan monitoring; semi-annually reporting on measures by SMO.	OBH	Continuously and ongoing

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
providers.	whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s). 3. Number and/or percent of plans of care that address participants' goals, as indicated in the assessment(s). 4. Number and/or percent of participants' plans of care that include the participant's and/or parent's/caregiver's signature, as specified in the approved waiver. 5. Number and/or percent of participants' plans of care that were	plan performance measures; 100% sample. 7. SMO database; 100% sample. 8. Record reviews; 100% sample. 9. SMO reports to the operating agency from the SMO; less than a 100% sample; RAND sampling methodology recommended by the OIG. 10. Person centered plan record reviews,	and generates; OBH and SMO aggregate and analyze. 9., 10. SMO collects, generates, aggregates and analyzes. 11. OBH and SMO collect, generate, aggregate and analyze. 12. SMO collects and generates; OBH and SMO aggregate and analyze. 13. OBH and SMO collect, generate, aggregate and	7. Ongoing 8. Quarterly data collection/ generation; annual data aggregation and analysis. 9. Quarterly data collection/ generation; continuous and ongoing data aggregation and analysis. 10. Quarterly data collection/ generation; semi-annual data aggregation and analysis. 11. Continuously and ongoing		

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	developed by an interdisciplinary team. 6. The State requires the SMO to report results of performance measures related to the treatment plan to the OBH and the IMT and requires corrective action, as appropriate. Corrective action is monitored, at minimum, quarterly by OBH and the IMT. BHSF (the Medicaid agency) is a member of IMT and monitors the OBH through this process. 7. Number and/or	financial records; less than a 100% sample with a 95% confidence level. 11. Record reviews, onsite; less than a 100% sample of case managers with a 95% confidence level. 12., 13. Record reviews, onsite; less than a 100% sample of case managers with a 95%	analyze.	12. Quarterly data collection/ generation; annual data aggregation and analysis. 13. Continuous and ongoing		

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	percent of participants whose plans of care were updated within 90 days of the last evaluation. 8. Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs. 9. Number and/or percent of participants who received services in the type, amount, duration and frequency specified in the plan of care. 10. Proportion of new	confidence level.				

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	waiver participants who are receiving services according to their PCP, within 45 days of PCP approval. 11. 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. 12. Proportion of participants reporting their care coordinator helps them to know what waiver services are available. 13. Number and/or					

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	percent of participant records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.					
Providers meet required qualifications.	1. Number and/or percent of waiver providers providing waiver services initially meeting licensure and certification requirements prior to furnishing waiver services. 2. Number and/or percent of waiver providers providing waiver services continuously meeting licensure	1., 2. OBH; 100% sample. 3. OBH contracts with a SMO to enroll qualified providers and pay claims; 100% sample. 4., 5., 6. Training verification	1., 2. OBH collect, generate, aggregate and analyze. 3. SMO collects, generates, aggregates and analyzes and sends to OBH. 4., 5. Training contractor collects and generates,	1., 2., 3. Continuously and ongoing 4. Monthly 5. Quarterly 6. Annually	OBH	Annually

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	requirements while furnishing waiver services. 3. Number and/or percent of waiver providers providing waiver services that have an active agreement with the SMO. 4. Number and/or percent of non-licensed/ non-certified providers of waiver services that meet training requirements. 5. Number and/or percent of provider trainings operated by SMO. 6. Number and/or percent of active providers (by provider type) meeting ongoing	records; 100% sample.	OBH aggregates and analyzes. 6. SMO collects, generates and aggregates; OBH analyzes.			

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	training requirements.					
The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight.	1. Number and/or percent of aggregated performance measure reports generated by the operating agency and reviewed by the SMA that contain discovery, remediation and system improvement for ongoing compliance of the assurances. 2. Number and/or percent of waiver amendments, renewals and financial reports approved by the State Medicaid Agency (BHSF) prior to implementation by the operating agency	1., 2. & 3. Reports to State Medicaid Agency (BHSF) on delegated administrative functions; 100% sample size.	1., 2. & 3. SMO collects, generates, aggregates, analyzes and sends to OBH.	1., 2. & 3. Monthly	OBH , SMO	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	(OBH). 3. Number and/or percent of waiver concepts and policies requiring MMIS programming, approved by the SMA prior to the development of a formal implementation plan by the operating agency.					
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by	1. Number and/or percent of providers that have payment recouped for waiver services without supporting documentation. 2. Number and/or percent of claims verified through the SMO's compliance audit to have paid in accordance with the participant's waiver	1. Routine Medicaid claims verification audits; representative sample of case managers with a 95% confidence interval. 2. SMO's compliance report; less	1. SMO collects, generates, aggregates and analyzes. 2. SMO collects and generates; OBH and SMO aggregate and analyze.	1. Continuously and ongoing. 2. Quarterly data collection and generation; continuous and ongoing data aggregation and analysis.	SMO	Continuously and ongoing

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
qualified providers.	treatment plan.	than a 100% sample with the RAND sampling methodology recommended by the OIG.				
The State identifies, addresses and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints.	1. Number and/or percent of reports related to the abuse, neglect or exploitation of participants where an investigation was initiated within established timeframes. 2. Number and/or percent of participants who received information on how to report the suspected abuse, neglect or exploitation of adults. 3. Number and/or percent of	1., 2., 100% sample, OBH performance monitoring. 3. A sample of case managers with 95% confidence; onsite record reviews. 4. 100% review, provider performance monitoring. 5. 100% review, OBH abuse,	1. OBH collects, generates, aggregates and analyzes. 2. SMO collects and generates; OBH aggregates and analyzes. 3. OBH and SMO collect, generate, aggregate and analyze. 4. SMO collects and generates; OBH	1. Monthly 2., 3.Continuously and ongoing 4. Weekly 5. Monthly	OBH	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance measures)*	**Discovery Activity** *(Source of data and sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of analysis and aggregation*
	participants who received information regarding their rights to a State Fair Hearing via the Notice of Action form. 4. Number and/or percent of grievances filed by participants that were resolved within 14 calendar days, according to approved waiver guidelines. 5. Number and/or percent of allegations of abuse, neglect or exploitation investigated that were later substantiated.	neglect or exploitation database.	aggregates and analyzes. 5. OBH collects generates, aggregates and analyzes.			

1915(i) State Plan Monitoring

The following table presents the process for systems improvement as a result of aggregated discovery and remediation activities from the 1915(i) SPA:

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Quality management meetings (QAPI): ▪ To assess system changes ▪ To focus on implementation of the overall concurrent waiver program and activities specific to Medicaid managed care, including reporting requirements, refining of reports and implementation of EQR activities	▪ QAPI Committee, including BHSF, OBH, SMO and IMT ▪ IMT and OBH monitor committee	▪ Quarterly	▪ Work on operational details to ensure that quality activities are consistent with QIS and contract requirements. ▪ Review QIS activities and provide direction, feedback and support for strategic quality issues. ▪ Operationalize the Louisiana 1915(i) PMs and move to the next level of trending, analyzing and setting benchmarks for all services delivered through the SMO. ▪ Develop benchmark priorities (after PMs are implemented and the SMO has an initial baseline year of service experience). ▪ Monitoring includes compliance with contracts and the State and Medicaid waivers, review of findings from other monitoring activities, corrective action plans, service utilization measures, making recommendations and providing technical assistance.

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
▪ Onsite reviews of SMO operations: – Includes documentation review and onsite interviews – May include review of Mental health (MH)/developmental disabilities (DD)/substance abuse services care management records	▪ OBH coordinates review	▪ Annual/biannual	▪ Review of administrative operations (financial management, information technology, claims) and clinical operations (care management, utilization management, network management, quality management). ▪ Any compliance issues found on the review will require the submission of a corrective action plan to the IMT for approval and ongoing monitoring.
▪ Meetings to review numerical data and narrative reports describing clinical and related information on health services and outcomes ▪ QI reporting minimally includes statistical analysis, root cause analysis, analysis of barriers and improvement interventions ▪ Areas of non-compliance or opportunities for improvement are monitored for progress made in implementing corrective actions or improvement in the quality of service or care provided to enrollees	▪ IMT, which is comprised of representatives from OBH, DHH, BHSF, OJJ, DCFS, DOE, waiver participants and the SMO	▪ Quarterly (meetings)	▪ IMT activities will focus on quality improvement, as well as implementation, with focus in both clinical and non-clinical areas. • Monitor availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special healthcare needs, coverage and authorization of services, emergency and post-stabilization services, enrollment and disenrollment, grievance systems, health information systems, compliance

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
			with contract, and State and federal Medicaid requirements. ▪ Quarterly report results are documented in IMT meeting minutes and communicated to stakeholders and the QAPI Committee. ▪ Quality results are reported to providers through plan mailings. ▪ Members and families receive QAPI activity information through member newsletters.
Corrective action plans	▪ Developed by the SMO at the request of OBH ▪ Submitted to IMT for monitoring	▪ Areas for improvement will be prioritized and monitored on a day-to-day basis; progress presented quarterly to the IMT for comments and guidance	▪ Analysis of performance measure reporting, findings from IMT and external reviews, analysis of grievances and appeals reports, record reviews by the SMO and review of provider network for adequacy and choice will be the basis for an ongoing corrective action/quality improvement plan. ▪ The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress and target dates for completion.

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Ongoing monitoring activities using performance measures specific to the 1915(i) SPA	▪ DHH, BHSF, SMO, case managers will collect and analyze the data and report to the State	▪ Ranges from monthly to annually to continuously and ongoing	▪ Through tracking and trending of performance reporting and findings from other oversight activities, the OBH and the SMO expect to be able to identify any provider-specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. ▪ As examples, with trending and tracking of complaints: a specific provider might be identified who needs additional training or even termination from the network; recurring and excessive delays in implementing treatment plans might result in changes in internal assessment/ authorization processes; and as a final example, inconsistencies identified in level of need determinations could result in additional training to ensure that staff have the same understanding of level of need criteria.

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Review of quality strategy and development of a new quality strategy for the next year	▪ OBH quality staff, SMO, stakeholders, IMT ▪ Stakeholders include governmental agencies, providers, consumers and advocates	▪ Annually (or more frequently if necessary)	▪ Development process begins with an assessment of the accomplishments of the prior year's quality plan, the EQR technical report and input from committees and stakeholders. ▪ Areas of focus for quality activities include quality improvement measures, improvement projects and performance indicators.
EQR to evaluate the SMO	▪ External vendor performs EQR ▪ EQR contracted by OBH ▪ Monitored by IMT, which uses EQR information to update the QIS and to initiate and develop quality improvement projects	▪ Annually	▪ Provides detailed information on the regulatory compliance of the SMO, as well as results of PIPs and PMs. ▪ The EQR report provides information about the quality, timeliness and accessibility of care furnished by the SMO, assesses its strengths and weaknesses, and identifies opportunities for improvement.
PIPs ▪ Results (validation of PIPs) analyzed and compared to expected outcomes	▪ SMO performs PIPs and collects and presents data ▪ Contracted EQR validates PIPs ▪ IMT monitors PIPs	▪ Ongoing, annual reporting	▪ Monitors quality and performance improvement program. ▪ Focus on clinical and non-clinical areas.

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
▪ Consumer survey developed to measure adult and child consumer experience and satisfaction with the SMO ▪ Results incorporated into the overall QIS	▪ SMO administers survey ▪ OBH approves survey and methodology ▪ OBH and IMT monitor	▪ Annually	▪ The survey contains questions designed to measure at least the following dimensions of client satisfaction with SMO providers, services, delivery and quality: – Overall satisfaction with SMO services, delivery and quality – Consumer knowledge of managed care from a patient's perspective – Consumer knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process – Cultural sensitivity – Consumer perception of accessibility to services, including access to providers
▪ A provider satisfaction survey is included in the annual statistical reporting to the State: ▪ The purpose is to solicit input from providers regarding levels of satisfaction with program areas, such as claims submission and payment, assistance from the SMO and	▪ SMO develops survey ▪ OBH and IMT monitor	▪ Annually	▪ Provider satisfaction survey is State-approved. ▪ The survey is developed by the SMO and approved for use by the State agency. ▪ Monitors availability of services, timely access to care, coordination/continuity of services, and coverage and

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
communication			authorization of services.
▪ Behavioral health grievance and appeals review: – Data and information used to assess quality and utilization of care and services ▪ Results from ongoing analysis are applied to evaluation of grievances with quality expectations	▪ SMO reports address type of grievance, source of grievance, type of provider (MH, DD, SA), grievance resolution, as well as the number, types and disposition of appeals ▪ State reviews ▪ IMT monitors process	▪ Quarterly	▪ The SMO will revise its reporting on grievances and appeals to identify those made specifically by or on behalf of Louisiana 1915(i) HCBS participants/ applicants. ▪ Monitors availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special healthcare needs, coverage and authorization of services, emergency and post stabilization services, enrollment and disenrollment, grievance systems, and health information systems.

1915(b) Waiver Compliance Assurance Strategies

The following tables present the compliance assurance strategies for the 1915 (b) Waiver:

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice N/A requesting waiver	Marketing	Enroll disenroll N/A requesting waiver	Program integrity	Information to beneficiaries	Grievance	Timely access	PCP/specialist capacity	Coordination/ continuity	Coverage/ authorization	Provider selection	Quality of care
Accreditation for non-duplication												
Accreditation for participation							X				X	X
Consumer self-report data					X		X					X
Data analysis (non-claims)						X						X
Enrollee hotlines					X	X	X	X	X			X
Focused studies												
Geographic mapping							X	X				
Independent assessment							X					X
Measure any disparities by racial or ethnic groups							X			X		
Network adequacy assurance by							X	X				

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice N/A requesting waiver	Marketing	Enroll disenroll N/A requesting waiver	Program integrity	Information to beneficiaries	Grievance	Timely access	PCP/specialist capacity	Coordination/ continuity	Coverage/ authorization	Provider selection	Quality of care
plan												
Ombudsman												
Onsite review		X			X	X			X	X	X	
Performance improvement projects							X		X			X
Performance measures								X		X		X
Periodic comparison of number of providers							X	X				
Profile utilization by provider caseload												
Provider self-report data												
Test 24/7 PCP availability												
Utilization review				X						X		
Other: (describe)												

1915(b) Waiver Monitoring

As required by CFR 438.204(b)(3), Louisiana regularly monitors and evaluates the SMO's compliance with the standards. OBH engages in a variety of methods to assure that the SMO develops and implements a quality plan, meeting the expectations communicated through the quality strategy, the managed care contract, compliance requirements specified within the Balanced Budget Act regulations and the approved waivers.

The IMT meets monthly to review numerical data and narrative reports describing clinical and related information on health services and outcomes. Areas of non-compliance or opportunities for improvement are monitored for progress made in implementing corrective actions or improvement in the quality of service or care provided to enrollees. Quality improvement monitoring meetings composed of representatives from OBH and SMO meet quarterly. Monitoring includes, but is not limited to, compliance with contracts and the State and Medicaid waivers, review of findings from other monitoring activities, corrective action plans and service utilization measures, making recommendations and providing technical assistance, availability of services, network adequacy, timely access to care; cultural consideration; primary care and coordination/continuity of services; special healthcare needs, coverage and authorization of services, emergency and post-stabilization services, enrollment and disenrollment, grievance systems, health information systems, compliance with contract, and State and federal Medicaid requirements.

a. _____ Accreditation for non-duplication
b. __X__ Accreditation for participation (i.e., as prerequisite to be Medicaid plan)
- _X_ National Committee on Quality Assurance
- ___ Joint Commission on Accreditation of Healthcare Organizations
- ___ Accreditation Association for Ambulatory Health Care
- _X_ Other (please describe)

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO must meet NCQA or the Utilization Review Accreditation Committee (URAC) Health Plan Accreditation or agrees to submit application for accreditation at the earliest possible date, as allowed by NCQA or URAC, and once achieved, maintains accreditation through the life of this agreement.
- Frequency of use: The SMO must meet accreditation or submit, at the earliest application, and achieve no later than two years after contracting. The SMO must maintain the accreditation for the life of the contract.
- How it yields information about the area(s) being monitored: Accreditation information is used to monitor:
  - Timely access
  - Provider selection
  - Quality of care

The accreditation will be utilized to ensure the quality and effectiveness of the services provided. The accreditation will be utilized to identify issues regarding quality of care, access and provider selection. After review of the results, OBH may require a written plan for addressing low performance. Accreditation results are reported and reviewed by the State's IMT, which includes consumer and family representatives, as well as the State. The accreditation and results are included in the SMO's performance improvement work plan and annual quality evaluation and are reviewed as part of the EQR processes.

c. _X__ Consumer self-report data

___ Consumer Assessment of Health Plan Study (please identify which one(s))

_X_ State-developed survey

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO will conduct a state approved consumer satisfaction survey for its enrolled populations, which may vary slightly from the existing satisfaction tools. The survey will build upon previous national standards surveys from SAMHSA for OBH served clients, including the Substance Abuse Prevention and Treatment (SAPT) Block Grant required surveys. The survey utilizes the sampling method and format defined by the NCQA.
- Frequency of use: The consumer satisfaction survey is conducted annually. The sample for each survey is drawn from Medicaid enrollees who received a covered service in the previous year.
- How it yields information about the area(s) being monitored: Client satisfaction survey information is used to monitor:
  - Information to beneficiaries
  - Timely access
  - Quality of care

The results of the survey must be submitted to OBH. Findings from the results are incorporated into the QIS. The results of the survey will be utilized to measure and evaluate the client's perception of the quality and effectiveness of the services received. Results will assist OBH in monitoring the satisfaction of participants, identifying gaps in services and evaluating needs in future policy development.

The survey will include the demographic information of:

- Provider/agency in which services are being received
- Participant's age, gender and race or ethnic group
- Modalities of services received during treatment service

This information is utilized to identify issues for performance measures regarding quality of care and to improve the consumer information for member use. After review of the results from the satisfaction survey, OBH may require a written plan for addressing low performance. Survey results are reported and reviewed by the State's IMT, which includes consumer and family representatives, as well as the State. The survey instrument and results are included in the SMO's performance improvement work plan and annual quality evaluation and are reviewed as part of the independent assessment processes.

___ Disenrollment survey
___ Consumer/beneficiary focus groups

d. _X___ Data analysis (non-claims)
___ Denials of referral requests
___ Disenrollment requests by enrollee
___ From plan
___ From PCP within plan
_X_ Grievances and appeals data

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO is required to track the grievances and appeals system. Grievance and appeal data are included in quarterly QI reporting and are reviewed, at least annually, by the State IMT. Data are also included in QI annual reports.
- Frequency of use: Data are gathered and reported quarterly with quarterly review and annually, at a minimum.
- How it yields information about the area(s) being monitored: Grievance and appeal data are used to monitor:
  - Grievances
  - Quality of care

This data is integrated into the performance measures as part of the overall State performance improvement process. The data are analyzed to identify trends, sentinel and adverse events. The findings are reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. Performance measures are implemented when indicated by findings.

___ PCP termination rates and reasons
___ Other (please describe)

e. _X___ Enrollee hotlines operated by State

- Applicable program: SMO
- Personnel responsible: SMO
- Detailed description: The SMO is required to have staff on site available by 800 phone number, 24 hours a day/365 days a year, to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls range from non-urgent requests for referral to behavioral health crises*. The 800 number is printed in the enrollee benefit book and associated materials*. The 800 number for each contractor is communicated to clients individually, including in written materials provided to them and on Contractor/State of Louisiana websites. The helpline shall include telephone crisis intervention, risk assessment and consultation to callers, which may include family members or other community agencies regarding substance abuse issues. Community resources, such as contact information to their local region, authority or human service district, will be provided to the caller.
- Frequency of use: The 800 number is available 24 hours a day, every day.
- How it yields information about the area(s) being monitored: The client 800 number is used to monitor:
  - Information to beneficiaries
  - Grievances
  - Timely access
  - Coordination/continuity
  - Quality of care

  The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, identifying and addressing trends. If deficiencies are noted, the Contractor must perform corrective action until compliance is met. *The information obtained from the enrollees is integrated into the SMO's annual QM plan, as well as analysis process, as part of the State quality work plan and reported to the State IMT*. The committee members discuss the findings to identify opportunities for improvement. The analysis is part of the State quality work plan and is reported to the State IMT.

f. _____ Focused studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. _X___ Geographic mapping of provider network

- Applicable program: SMO
- Personnel responsible: SMO
- Detailed description: Through geographic mapping, distribution of provider types across the state is identified. Examples of provider types shown through mapping

include psychiatrists, psychologists, social workers, care management entities, substance abuse treatment providers, EBPs, etc.

- Frequency of use: Geographic mapping is generated and reported on a quarterly basis.
- How it yields information about the area(s) being monitored: Geographic mapping information is used to monitor:
  - Timely access
  - Specialist capacity

  The software program produces a report that is analyzed for compliance with the State access and capacity requirements. The analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the Contractor must perform corrective action until compliance is met.

h. _X_ Independent assessment of program impact, access, quality and cost-effectiveness

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency delegated to plan, EQR, other contractor): An independent third party will be contracted to perform this activity.
- Detailed description of activity: The State will hire an independent assessor to assess quality of care, access to services and cost-effectiveness of this new mental health and substance abuse delivery system, as required by the waiver. Louisiana will rely upon the CMS independent assessment guide to meet this requirement.
- Frequency of use: Biannually for the first two waiver periods.
- How it yields information about the area(s) being monitored: The independent assessment will be used to monitor:
  - Timely access
  - Quality of care

  In particular, the assessment is targeted to monitor the above topics. The data collected is used to: 1) analyze the effectiveness of the new programs; 2) develop a quantitative, regional understanding of access to the new behavioral health care service delivery system, including the subsystems and their relation; 3) identify needs for further contracting and/or 4) identify processes and areas of quality of care for detailed study through ongoing performance measures. The analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

i. __X__ Measurement of any disparities by racial or ethnic groups

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO is required to report demographic data (including racial/ethnic data), outcomes measures, utilization and special needs population (target population) data to the State through the required OBH data.
- Frequency of use: The State OBH data is collected on at least an annual basis, and reports addressing disparities of access are published annually.
- How it yields information about the area(s) being monitored: The measurement of any disparities by racial or ethnic groups will be used to monitor:
  - Timely access
  - Coverage and authorization of care

  The disparity analysis provides information regarding the effectiveness of the program. This information is utilized for performance measures. The primary focus is to obtain information about problems or opportunities for improvement to implement performance measures for quality, access or coordination of care or to improve information to beneficiaries. This data is also used for external reporting to federal partners.

j. __X__ Network adequacy assurance submitted by plan

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.
- Frequency of use: Documentation was submitted at the time of contracting and is submitted any time there is a significant change that would affect adequate capacity and services or at enrollment of a new population. Certain network reports are submitted annually.
- How it yields information about the area(s) being monitored: Network reports provide information on:
  - Timely access
  - Coordination/continuity

  Network adequacy will be addressed through performance measures that focus on specific time measures and the percentage of providers retained contracted outside of the SMO. Performance indicator data is reported quarterly in the State quality work plan and is reviewed each quarter by the State IMT. A performance indicator report is also included in the Quality Annual Report.

The data is used to: 1) develop a quantitative, regional understanding of the health care or service delivery system, including the subsystems and their relation; 2) identify needs for further data collection and 3) identify processes and areas for detailed study. The result of the analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. The data from all sources is analyzed for compliance. If indicated, the Contractor is required to implement corrective action. The identified aspects are integrated into the implementation of performance measures.

k. _____ Ombudsman

l. __X__ Onsite review

Onsite Review – EQR in Conjunction with Representatives of IMT Staff Members

- Applicable program: SMO
- Personnel responsible: External entity identified by State (Request for Proposal will be released for this contract)
- Detailed description: EQR is a process by which an EQRO, through a specific agreement with the State, reviews SMO policies and processes implemented for the Louisiana behavioral health program. EQRs include extensive review of SMO documentation and interviews with SMO staff. Interviews with stakeholders and confirmation of data may also be initiated. The reviews focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts, as needed, and any individual provider follow-up.
- Frequency of use: EQR is done annually.
- How it yields information about the area(s) being monitored: EQR provides monitoring information related to:
  - Marketing
  - Information to beneficiaries
  - Grievance
  - Coordination/continuity
  - Coverage/authorization
  - Quality of care

  The EQR review allows a review of automated systems and communication with the contractor staff that perform each of the above processes. It also obtains additional information that was not provided during State monitoring through conference calls, meetings, documentation requests or quarterly reports. The data from all sources is analyzed for compliance. If indicated, the Contractor is required to implement corrective action. The result of the analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify

opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

m. _X___ Performance improvement projects
_X_ Clinical
_X_ Non-clinical

- Applicable program: SMO
- Personnel responsible: SMO
- Detailed description: The SMO must conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The SMO must consult with OBH and the CSoC governance group regarding at least one of the topics of the PIPs.
- Frequency of use: Two PIPs must be in process each year. The Contractor shall report the status and results of each PIP to OBH. Each PIP must be completed in a reasonable time period, so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.
- How it yields information about the area(s) being monitored: PIPs provide monitoring information related to:
  - Access to care
  - Coordination/continuity of care
  - Quality of care

  PIPs are chosen based upon the information obtained through other monitoring processes, as noted in this section. The QI work plan provides information about the aspects identified for performance improvement projects. The PIPs must involve the following:

  - Measurement of performance using objective quality indicators
  - Implementation of system interventions to achieve improvement in quality
  - Evaluation of the effectiveness of the interventions
  - Planning and initiation of activities for increasing or sustaining improvement

  The data is used to develop a quantitative, regional understanding of the health care or service delivery system, including the subsystems and their relation; identify needs for further data collection and identify processes and areas for detailed study. The result of the analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes.

n. _X_ Performance measures
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

- Applicable program: SMO
- Personnel responsible: SMO
- Detailed description: The State has established a comprehensive listing of performance measure areas, entitled performance indicators, for the SMO's implementation of the Louisiana Behavioral Health Plan.

The State has established a comprehensive listing of performance measure areas, entitled performance indicators, for each contractor's implementation of the mental health reform. The performance measures are dynamic, based upon current system needs or gaps responsive to consumer needs, and are modified periodically, as needed. Topics of performance indicators include the SAMHSA NOMS indicators, including such topics as: institutional utilization, penetration rates for outpatient utilization, average lengths of stay, recidivism rates, abstinence, employment/education, crime and criminal justice involvement, stability in housing, social connectedness, access/capacity, retention, perception of care, cost-effectiveness and use of evidenced-based practices.

- Frequency of use: Performance indicators are included on the QI work plan and reviewed quarterly in the IMT. A year-to-date performance indicators report is submitted as part of the QI quarterly report. Other data package reporting is done each month. Audits are done each year.
- How it yields information about the area(s) being monitored: Performance measures provide information related to:
  - PCP/specialist capacity
  - Coverage and authorization of care
  - Quality of care

Performance indicator data are reported in the QI work plan and are reviewed by the IMT. A performance indicator report is also included in the QI quarterly report and annual report. The indicators aid in the identification of opportunities for quality improvement. In addition, this information aids in the assessment of initiative effectiveness. The contract also establishes expectations around continuous quality improvement that include participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators and development and implementation of improvement plans.

The result of the analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes.

o. _X___ Periodic comparison of number and types of Medicaid providers before and after waiver

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO shall annually report the number and types of Title XIX practitioners (by service type, not facility or license type) relative to the number and types of Medicaid providers at the start date of the contract. For example, the number of licensed clinical social workers prior to the start of the contract versus the current number of peer support specialists. The SMO shall annually report the number and types of Title XIX providers relative to the number and types of Medicaid providers prior to the start date of the contract.
- Frequency of use: Annually
- How it yields information about the area(s) being monitored: Performance measures provide information related to:
  - Timely access
  - PCP/specialist capacity

The analysis is part of the State quality work plan and is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, the Contractor must perform corrective action until compliance is met.

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ____ Provider self-report data
___ Survey of providers
___ Focus groups

r. ____ Test 24 hours/7 days a week PCP availability

s. __X__ Utilization review (e.g., emergency room, non-authorized specialist requests)

- Applicable programs: SMO
- Personnel responsible (e.g., State Medicaid, other State agency, delegated to plan, EQR, other contractor): SMO
- Detailed description of activity: The SMO conducts statistically valid sample reviews. The Contractor shall perform ongoing monitoring of UM data, onsite

review results and claims data review. The designated SRS staff will review the Contractor's utilization review process.

- Frequency of use: Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to utilization review are reported in the State Quality Report and are reviewed by the State IMT on a quarterly basis. Providers shall have over utilization and under utilization reviews through the use of outlier reports and regular utilization reports and analyses.
- How it yields information about the area(s) being monitored: Utilization management data can be used to monitor:
  - Program integrity
  - Coverage/authorization

The data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and Contractor level. This information is primarily used for provider and enrollee monitoring and is part of the State quality work plan. The analysis is reported to the State IMT. The committee members discuss the findings to identify opportunities for improvement. If areas for improvement are noted, the Contractor works with the specific provider noted or incorporates the identified aspects into the implementation of performance measures. Providers shall have over utilization and under utilization reviews through the use of outlier reports and regular utilization reports and analyses. Utilization management data is used to monitor program integrity and coverage/authorization decisions and denials. If the utilization review process identifies issues with program integrity, the Contractor shall follow up with providers, utilize corrective action plans, when indicated, recoup overpayments or report abusive or fraudulent claiming to the Medicaid Fraud Control Unit via the State Medicaid Agency.

Health Information Technology

In accordance with 42 CFR 438.242, the SMO must operate a management information system (MIS) capable of maintaining, providing and documenting information. The MIS will be capable of collecting, analyzing, integrating and reporting data sufficient to document the SMO’s compliance with contract requirements. The SMO must collect and ensure accurate and complete data on enrollees, providers and services through a data system, as specified by the State. To ensure data accuracy, MCOs will cooperate with the State in carrying out data validation steps. OBH has developed an operational data collection plan to monitor actual program performance with respect to service access and health status/outcomes. The components of the plan include encounter reporting; summary utilization reports; quality information, including focused quality of care studies, member satisfaction surveys, financial reports and grievance and appeals reports; access to care; medical outcomes and health status.

The SMO will be required to submit an electronic record of every encounter within 15 days of the close of the month, in which the encounter occurred, was paid for or was processed, but no later than 180 days from the encounter date. OBH will ensure

compliance with reporting requirements and may withhold capitation payments until encounter data requirements are met to enforce compliance. Non-risk payments are not made until the invoice is supported with submitted encounters. The following IS areas are assessed by OBH annually:

- Member enrollment and eligibility
- Membership and capitation reconciliation
- Reporting
- Electronic data interchange
- Disaster recovery

The OBH gathers and monitors encounter data from the SMO to assess over utilization and under utilization using formats consistent with the formats and coding conventions of the CMS 1500, UB04 or other formats required under HIPAA. OBH will ensure compliance with reporting requirements and withholding capitation payments until encounter data requirements are met. Non-risk payments may not be made, if encounters to support the invoice are not submitted. Should the State determine that encounter data errors are not decreasing, as expected, the State may require that the SMO bear the cost of processing all encounters that consistently exceed the error tolerance.

As required by CFR 438.204(f), the MMIS will be used to monitor the encounter data submitted by the SMO. The MMIS stores and utilizes client eligibility records, managed care enrollment records, premium collection records and provider eligibility records for:

- Claims processing
- Encounter record processing
- Premium collection per capita payments
- Related tracking and reporting

The SMO shall develop a CAC consisting of licensed network providers. Practice guidelines shall be developed in consultation with this committee. Practice guidelines shall be based on valid and reliable clinical evidence (evidence-based practice) or a consensus of professionals in the field. Practice guidelines shall address the needs of enrollees and shall be reviewed and updated periodically, as appropriate and in accordance with changes and developments in clinical research. All utilization management decisions, enrollee education decisions, coverage of services decisions and all other decisions covered by the practice guidelines shall be consistent with the practice guidelines. Practice guidelines shall be disseminated to providers and, upon request, to enrollees.

3

Improvement and Interventions

Interventions for improvement of quality activities are determined based upon review and analysis of results of each activity and ongoing assessment of participant/healthcare needs.

Performance Measures

PMs provide information regarding directions and trends in the aspects of care being measured. This information is used to focus and identify future quality activities and direct interventions for existing quality activities. For measures progressing toward or meeting goals, ongoing measurement with barrier analysis may continue. Measures meeting goals for at least two consecutive cycles may continue to be measured or, to ensure improvement is maintained, may be placed on an alternative year re-measurement cycle. For measures demonstrating consistent lack of progress or goal achievement, corrective action plans may be required to assist the SMO in meeting measurement-expected results. The corrective action must demonstrate appropriate actions to positively impact measurement results.

Selected PMs are validated during the EQR process, with a corrective plan required for areas of non-compliance. Sanctions may be implemented should other efforts of cooperation fail.

Performance Improvement Projects

A PIP is intended to improve care, services or member outcomes in a focused area of study. OBH, in conjunction with the SMO, has identified a number of PMs and PIPS that address a range of priority issues for the Medicaid population. These measures have been identified through a process of data analysis and evaluation of trends within the Medicaid population. Consumer, advocate and provider input were accessed throughout the design process for the comprehensive system for behavioral health services, including the CSoC for at-risk children and youth. Final approval of PMs is the

responsibility of OBH. The performance measure results will be reviewed annually and benchmarked with established performance standards/goals.

The State quality strategy general expectations for PIPs include:

- Year one: PIP development process and baseline results; analysis identifies interventions for re-measurement year
- Year two: Interventions implemented and results reported (reported results may not include full impact of interventions based upon timing issues)
- Year three: Re-measurement and ongoing improvement, with adjustment in interventions as appropriate
- Year four: Re-measurement demonstrating ongoing improvement or sustainability of results
- Future years to be determined based upon results, sustainability and enrollee needs

PIPs will be validated during the EQR process, and results are expected to demonstrate achievement or progress toward achievement of the OBH identified goal. For areas of noncompliance, corrective action plans can be required, which will be monitored for improvement in the IMT. Sanctions may be implemented should all other methods of cooperation fail to occur.

During presentation and discussion of performance metrics and PIPs at the IMT, opportunities are sought to implement cross-organizational or agency quality activities, interventions or changes and improvement in information system identification or processing of data and identification of topics for focused quality study.

4

Strategy Review and Effectiveness

How the Quality Strategy is Reviewed

Prepaid Inpatient Health Plan Reporting Requirements

The time frame for reports due to the State are as follows:

- Annual reports are due to the State on June 30 of each year, except for PIP reports and the revised QAPI, which are due to OBH by no later than July 31 of each year, and financial reports, which are due 90 days following the end of the state fiscal year (SFY).
- Quarterly financial reports.
- Annual reports submitted on June 30 contain data collected from January 1 through December 31 of the preceding calendar year.

Clinical reports will be timely, accurate and complete. The submission of late, inaccurate or otherwise incomplete reports shall constitute a failure to report, and the SMO shall be subject to corrective actions or penalties and sanctions.

- OBH shall furnish the SMO with timely notice of reporting requirements, including acceptable reporting formats, instructions and timetables for submission and such technical assistance in filing reports and data as may be permitted by the OBH's available resources. OBH reserves the right to modify, from time to time, the form, content, instructions and timetables for collection and reporting of data. OBH agrees to involve the SMO in the decision process prior to implementing changes in format and shall ask the SMO to review and comment on format changes before they go into effect. The timetable for new reports shall be negotiated by the SMO and OBH, taking into consideration the complexity and availability of the information needed.
- Financial reports or other data shall be received on or before the scheduled due date. All required reports shall be received by OBH no later than 5:00 PM Eastern Time on the due date. Requests for extensions shall be submitted to OBH in writing. All

reports remain due on the scheduled due date, unless OBH approves the extension request in writing.

- The SMO shall submit data and measurements to OBH annually for quality of care and service measures and PIPs.
- Additional quality measures may be phased in over the term of the contract at the discretion of OBH.
- The SMO shall use the Health Plan Employer Data and Information Set (HEDIS) technical specifications applicable to the subject reporting year. The SMO may seek, and receive, written approval from OBH for revisions or amendments to the HEDIS specifications, provided it does so before April 1.
- For all measurements without pertinent HEDIS specifications, the SMO shall use technical specifications provided by OBH. Each annual report shall contain an explanation of how the data was calculated.
- If the SMO does not adhere to the reporting and data submission requirements and deadlines specified within this contract, OBH may impose monetary penalties. OBH shall communicate the penalties in writing to the SMO and OBH's fiscal agent.
- As noted in the contract, certain reports must include a subset report for Section 1915(c) waiver enrollees.

Ongoing Reports

- Written reports of findings of the provider network analyses. Whenever network gaps are identified, the SMO shall submit to OBH a network development plan within a timeframe specified by OBH
- Encounter data (within 15 days of the close of the month in which the specific encounter occurred, was paid for or was processed, whichever is later, but no later than 180 days from the encounter date)
- QAPI committee minutes

Monthly Reports

- Coordination of benefits

Quarterly Reports

- Grievance and appeal reports
- Fiscal monitoring report (within 60 days after the end of each SFY quarter)
  - Analysis of revenues and expenses
  - Claims processing report
  - Enrollment table report (quarterly report due 60 days, following end of the quarter)
  - Incurred but not reported (claims lag report)
  - Statement of financial position (balance sheet)
  - Statements of activities

Annual Reports

- A revised and updated QAPI program and a report on the SMO's progress toward performance improvement goals during the last 12 months
- Reports on all PIPs
- HEDIS PMs
- Non-HEDIS PMs, including member services PMs, payment denials, out of network services reports, utilization reports and timeliness of initial service delivery
- Provider satisfaction survey
- Consumer satisfaction survey
- Health plan stability reports, including network capacity
- Membership reports
- Summary of critical incident reports and crisis plans
- Enrollment table report (annual report due 90 days from the end of the year)
- Fiscal monitoring report (90 days after the end of the SFY)
  - Annual disclosure statement
  - Cost allocation plan
  - Independent audit – financial audit and supplemental schedules
  - Office of Management and Budget Circular A-133
  - Physician incentive arrangement (if any)
  - Reinvestment report
  - Related party transactions and obligations
  - Retained earnings (deficit)/fund balance
  - Risk pool analysis
  - Statement of activities and changes in net assets
  - Statement of cash flows
  - Statement of financial position reconciliation
- An annual audit and a final reconciliation completed no sooner than six months following the end of the SFY on June 30

CMS Reporting Requirements

- The annual evaluation included in the QIS will provide a more detailed overall analysis and assessment of the effectiveness of the QIS strategy, including, but not limited to, the following:
  - Quantifiable achievements
  - Data and numeric analysis
  - Discussion of variations from expected results
  - Barriers and obstacles encountered
  - Interventions planned to overcome barriers
  - How participant and system changes were improved as a result of QIS initiative results
  - Best practices and lessons learned, with resultant changes to the following year's strategy
- The biannual 1915(b) waiver includes a summary of each strategy outlined in the 1915(b) waiver

5

Opportunities

Through the QIS, a number of successful outcomes will be achieved with the inception of the managed care waiver. One of the major achievements will be the use of the IMT as a central forum, focusing quality across Medicaid behavior funded programs and waivers. This process will allow for valuable discussion, sharing of perspectives and encouraging input into quality activities. These exchanges will serve to enhance knowledge and appreciation of care and services concerns across programs, divisions and external organizations and through resultant quality initiatives.

In addition, the IMT and QIS will have value in providing ongoing quality updates and status reports to the governance committee. Providing consistent information will result in positive support for continued quality activities and offered feedback of significant issues, with potential for improvement through the quality process.

Another major area of strength will be ongoing partnerships with community providers. Through disseminating information and results of quality initiatives to community providers via committee forums, we will receive valuable input resulting in program and system improvements. In partnering with the providers on quality activities, we will be able to develop clinical guidelines with local provider input and support.

Through rigorous quality processes, Medicaid managed care will be successful in improving or maintaining quality results and improving care and services to Medicaid participants during times of SMO transition.

The IMT, through the QIS process, will enhance the available data set. This new data set will expand the scope of QIS activities, including additional populations and domains of care.

Going forward, the QIS process will be more rigorous in setting specific improvement goals and, through the analysis process, determine if appropriate adjustments are required.

Through the IMT, it will identify that participants have expertise in various aspects of the quality process. Therefore, the IMT will leverage the skills and abilities of task force participants to enhance and strengthen overall skills and knowledge to ensure a path of ongoing improvement.