Department of Health and Hospitals
Office of Behavioral Health

Quality Improvement Strategy

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Background

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

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

The goals of the LBHP are to:

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

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

Since the implementation of managed care, enrollees have:

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

The LBHP operates under several federal authorities, including:

- 1915b waiver, which implements managed care;
- 1915b(3) waiver, which permits savings to be used to provide additional services;
- 1915(c) waiver, which provides specialized home and community-based services to at-risk children and youth eligible for Medicaid; and
- 1915(i) state plan amendment, which provides specialized home and community-based services Medicaid eligible adults who have acute stabilization needs, a serious mental illness, a major

mental disorder, or who previously met any of these criteria and need subsequent medically necessary services for stabilization and maintenance.

Purpose of the LBHP Quality Improvement Strategy

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

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

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

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

Assessing Quality and Appropriateness of Care and Services

The Office of Behavioral Health has structured its quality improvement system to address all waiver requirements and to meet the goals of the HCBS quality framework and the Triple Aim. This structure also ensures stakeholders are active in the quality improvement process and includes several key committees tasked with quality monitoring:

The CSoC Governance Board is comprised of executives of the Department of Children and Family Services, the Department of Education, the Office of Juvenile Justice, and the Department of Health and Hospitals, a representative from the Governor's Office, and family, youth and advocate representatives, who meet at least six times annually, and is responsible for:

- Overseeing the implementation and administration of the CSoC,
- Setting policy for the governance of the CSOC,
- Establishing policy and monitoring adherence
- Setting standards,
- Directing use of multiple funding sources,

- Directing the implementing agency, and
- Monitoring quality, cost, and adherence to standards.

The Board has two standing committees, which are detailed as follows:

- The Quality Assurance Committee which consists of staff from each agency with expertise in quality improvement and assurance. This committee meets on a quarterly basis and is responsible for:
    - Promoting, coordinating, and facilitating the active exchange of successful programs, practices, procedures, lessons learned, and other pertinent information of common interest to quality assurance.
    - Identifying streamlined techniques and benchmarked practices that enable cost-effective implementation of quality assurance processes and programs.
    - Formulating recommendations on the Board's position on issues related to quality assurance and quality improvement.
    - Monitoring the adequacy of the implementing agency's oversight of the CSoC.
- The Finance and Audit Committee which consist of the Undersecretary/Deputy Superintendent of Finance of each agency. This committee meets on an as needed basis and is responsible for:
    - Identifying and managing financial resources necessary to fund the various components of the CSoC
    - Ensuring the state maximizes available funds
    - Reviewing and making recommendations regarding the funding dedicated to the CSoC
    - Reviewing the financial status and needs of the CSoC and recommending policies for securing resources
    - Facilitating the development of and adherence to the necessary MOUs to support CSoC implementation.

The Interdepartmental Monitoring Team is comprised of subject matter experts from the Office of Behavioral Health, Bureau of Health Services Financing (Medicaid), Department of Education, Department of Children and Family Supports, and the Office of Juvenile Justice who meet on a monthly basis to:

- Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to determine patterns, trends, concerns, and issues in service delivery
- Provide oversight and monitoring of corrective action plans
- Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities

Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. The IMT works directly with the Statewide Management Organization regarding specific issues. In addition, the IMT directs and activates workgroups on specific activities of quality improvement as needed.

The Executive OBH/BHSF Joint Committee is comprised of executive level staff of the Office of Behavioral Health and Bureau of Health Services Financing (Medicaid) for the purpose of:

- Ensuring federal quality requirements and program goals are met,
- Adopting quality standards and measures,
- Taking action on recommendations from the Interdepartmental Monitoring Team and CSoC Governance Board,
- Establishing priorities and allocating resources,
- Establishing workgroups to design, coordinated, and integrate improvement strategies
- Troubleshoot critical issues

Table 1: Roles and Responsibilities of LBHP Quality Improvement Entities

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

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

State Access Standards

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

Provider Network

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

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

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

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

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

Provide for a Second Opinion from a Qualified Health Care Professional

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

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

- Member Handbook submitted annually
- Grievance data submitted quarterly

Adequate and Timely Coverage of Services Not Available in Network

If the network is unable to provide necessary services, including specialized services, covered under the contract to a particular enrollee, the SMO must adequately and timely cover these services out of network until a network provider is available. The SMO must coordinate with out-of-network providers with

respect to payment and ensure that cost to the member is not greater than it would be if the services were furnished within the network.

OBH monitors to assure this standard is met by reviewing and evaluating the following:
- Grievance data submitted quarterly
- Network Development and Management Plan

Provider Credentialing

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

OBH monitors to ensure this standard is met by reviewing and evaluating the following:
- Credentialing and Re-credentialing Policy submitted initially and annually

Timely Access to Services

The following table summarizes State-defined appointment access standards.

Table 3: Appointment Access Standards

Appointment Type	Access Standard	Criteria
Emergent	Within 1 hour of request after request of care is initiated; life-threatening emergencies must be managed immediately.	An individual in need of an emergent appointment is at serious or extreme risk of harm, such as current suicidal ideation with expressed intentions, recent use of substances resulting in decreased inhibition of harmful behaviors, repeated episodes of violence toward self and others, or extreme compromise of ability to care for oneself leading to physical injury.
Urgent	Within 48 hours of referral	An individual in need of an urgent appointment is at moderate risk of harm, such as suicidal ideation without intent or binge use of substances resulting in potentially harmful behaviors without current evidence of such behavior. Children/youth eligible for the CSoC must at least meet the urgent appointment standard.
Routine	14 calendar days	An individual in need of a routine appointment is at minimal to low risk of harm, such as absence of current suicidal ideation or substance use without significant episodes of potentially harmful behavior.

The SMO must:

- Require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.

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

OBH monitors to assure this standard is met by reviewing and evaluating the:
- Appointment access reports submitted quarterly
- Performance improvement project related to ambulatory follow-up submitted annually

Cultural Considerations

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

- Assess the diversity of members and the community,
- Provide linguistic services to assist members with accessing behavioral health services,
- Provide continuing education on cultural and linguistic competence to staff and providers,
- Develop a diverse and culturally and linguistically competent workforce, and
- Expand network services to include diverse service providers.

The SMO must:

- Respond to individuals with limited English proficiency through the use of bilingual/multi-cultural staff or language assistance services. The language line translation system must be available 24 hours per day, 7 days a week.
- Notify members, in writing, that alternative formats are available and provide information on how to access them.

- Translate all vital materials, when a language other than English is spoken by 1,000 individuals or 5% of the eligible population.
- Translate all non-vital materials when a language other than English is spoken by 3,000 individuals or 5% of the eligible population.
- Publish, distribute, and post to its website a member handbook in English, Spanish, and Vietnamese.
- Develop and maintain standards for the delivery of culturally and linguistically appropriate services for other multi-ethnic members including Latino, African American, Native American, and Vietnamese.
- Develop a Cultural and Linguistic Competency Plan that includes workforce development needs for staff and providers.

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

Members with Special Health Needs

Members with special health needs include:

- Pregnant females;
- Substance using women with young children;
- Women with co-occurring disorders and young children;
- Persons with HIV;
- Persons who are Intravenous (IV) drug users;
- Children with behavioral health needs in contact with other child-serving systems but not functionally eligible for CSoC; and
- The Permanent Supportive Housing population.

The SMO is required to:

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

OBH monitors to assure this standard is met by reviewing and evaluating:
- Treatment record review reports submitted monthly
- Plan of care performance measures submitted quarterly

Primary Care Coordination

The SMO must:

- Determine if members have a primary care physician. If the member does not, the SMO must refer the member to Bayou Health, the managed care delivery system for primary health care services operated by Medicaid.
- Document the member's primary care physician in the care management record, or if none, follow up on the primary care physician referral as part of the ongoing care management process.
- Attempt to obtain consent for release of information from the member or authorized representative to coordinate with the primary care physician and other health care professionals.
- Document the date of annual well care visits and track to assure primary care visits are scheduled and kept.
- If medications are prescribed by the SMO's providers, obtain a list of medications prescribed by the member's primary care physician and other specialists for a complete and reconciled medication list.
- Require that all network providers request a standardized release of information from each member to allow the network provider to coordinate treatment with the member's primary care physician.
- Coordinate care with the primary care physician, with the member's authorization, to promote overall health and wellness.
- Coordinate the services the SMO furnishes to the member with the services the member receives from any Bayou Health managed care organization.
- Share with other Bayou Health managed care organizations serving the member the results of its identification and assessment of any member with special health care needs to ensure services are not duplicated.
- Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR, parts 160 and 164 and 42 CFR Part II.

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

Coverage and Authorization of Services

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

The SMO must:

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

- Generate a prior authorization for each Psychiatric Rehabilitation Treatment Facility admission within 48 hours of completion of the screen.

OBH ensures this standard is met by reviewing and evaluating the SMO's:
- Prior authorization reports
- Written policies and procedures for processing requests for initial and continuing authorization of services
- Member Handbook submitted initially and annually

Notice of Action

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

The notice must explain the:

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

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

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

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

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

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

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

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

Compensation for Utilization Management Activities

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

The SMO must:

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

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

State Structure and Operations Standards

Provider Selection

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

Further, the SMO is required to contract with providers of behavioral health services who are appropriately licensed and/or certified, meet Louisiana's certification and credentialing criteria, agree to the standard contract provisions, and who wish to participate. The SMO is not permitted to subcontract with providers excluded from participation in federal health care program pursuant to section 1128 and section 1128A of the Social Security Act.

OBH monitors to ensure this standard is met by:

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

Confidentiality

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

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

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

Grievance System

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

Filing requirements:

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

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

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

Fraud, Waste, and Abuse Detection

The SMO is required to develop and maintain internal controls to prevent and detect fraud and must immediately report any suspicion or knowledge of fraud and abuse. The SMO has established a Fraud and Abuse unit comprised of experienced fraud and abuse reviewers who are charged with preventing, detecting, investigating, and reporting suspected fraud and abuse committed by providers, members, SMO employees, or other contracted entities.

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

OBH monitors to ensure this deliverable is met by:

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

State Measurement and Improvement Standards

Practice Guidelines

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

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

The SMO must use practice guidelines as a basis for decisions regarding utilization management, member education, provider education, coverage of services and other areas to which practice guidelines apply. The SMO must implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the SMO must monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures until such point that ninety percent (90%) or more of the providers are consistently in compliance, based on SMO measurement findings. Using information acquired through quality and utilization management activities, the SMO must recommend implementation of practice guidelines within the behavioral health delivery system, including measures of compliance, fidelity and outcomes and a process to integrate practice guidelines into care management and utilization reviews to OBH at least annually.

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

Quality Assessment and Performance Improvement Program

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

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

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

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

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

External Quality Reviews

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

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

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

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

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

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

Appendix A –Current Waiver and State Plan Performance Measures

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

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

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

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

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

Appendix B – Performance Improvement Projects

Topic	Rationale	Contract Year
Improve Member Access to Emergent, Urgent, and Routine Appointments	Avoiding delays in care is essential to prevent further deterioration of a member's condition.	All Contract Years
Improve the Number of CSoC Treatment Plans (Plans of Care) with Service Authorization at First Review	Appropriate referrals to community-based services at the time that the plan of care is developed helps decrease the risk of future out-of-home placement.	All Contract Years
Ambulatory Follow-Up After Hospitalization for Mental Illness	Ambulatory follow-up after inpatient treatment is an important component of care management and ensures that any recovery or stabilization that occurred during hospitalization is maintained and that further gains continue in the least restrictive environment possible.	Contract Year 2
Transitional Care (Previously Improving Rate of Ambulatory Follow-Up After Hospitalization for Mental Illness	Improve transitional care by ensuring appropriate inpatient discharge plans, which will increase the likelihood of attending ambulatory follow up appointments and thus reducing the probability of readmissions into an acute setting.	Contract Years 3 and 4