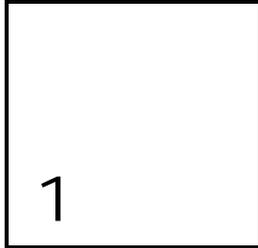


February 18, 2011      Final draft peered 2/18/11

Quality strategy for the  
Louisiana Behavioral  
Healthcare Prepaid Inpatient  
Healthcare Plan Waiver  
Louisiana Department of Health and  
Hospitals, Bureau of Health Care  
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 (BH) 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 (CHIP) 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 (IHCS), including home- and community-based services (HCBS) under a 1915(c) waiver for children that promote hope, recovery and resilience
- Improve quality by establishing and measuring outcomes
- Manage costs through effective utilization of State, federal and local resources

## Quality management strategy development

The Louisiana quality management strategy (QMS) 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 October 1, 2011. The QMS 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 QMS 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 QMS. The IMT includes representatives from the Health and Human Services (HHS) 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 QMS. Three main sources of information guide the updates to the QMS: 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 QMS 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. In addition, based on the availability of encounter data, the EQRO will conduct an optional encounter data validation activity. 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 QMS 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 SMO's contract under the Statistical Reporting Requirements. Findings from the results are incorporated into the QMS. Additional sources of member input include analysis of grievances, which are reviewed for quality purposes, as well as public forums, such as State and local coordinating councils (LCCs) for the CSoc and consumer and family advisory committees (CFACs) for adult participants. Each council and CFAC includes consumers and family members to advise SMO about the provision of services. The activities of the LCCs and CFACs, including participant input, are further described in the next section.

The IMT and SMO draft quality improvement goals and activities and integrate these into the QMS for review and feedback by key external stakeholders. OBH and the SMO submit the QMS 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](http://www.dss.la.gov/csoc), as well as the DHH website. The draft of the 2011 QMS was placed on the DHH Website, beginning October 1, 2010, at <http://www.dhh.louisiana.gov/publications.asp?D=1&CID=62>, indicating a 30-day period for public input. In addition, the SMO will present the 2011 QMS update for comments at a SMO Quality Assurance and Performance Improvement (QAPI) committee meeting and at their Family Coordinating Council (FCC) and CFAC meetings in the second quarter of 2011.

Suggested revisions to the proposed quality strategy, or improvement goals, are reflected in the updated QMS. Following approval by OBH, any amendments to the quality strategy will be shared with CMS. The final QMS is also published on the OBH Website.

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 CSoC LCCs and adult participant CFACs. 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 management program and the QMS.

## Quality management strategy implementation

The BHSF has delegated quality oversight responsibility for Medicaid behavioral health waiver programs to the OBH. OBH responsibilities include oversight and monitoring of quality plans and improvement activities through the established IMT. Through the efforts of the IMT, the QMS 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 quarterly IMT meetings
- Coordination of the annual on-site review

Each organization or governmental agency represented on the IMT has its own quality staff that is accountable for all phases of the quality management (QM) process. IMT representatives link these quality 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 QMS 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 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. The quarterly presentations 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
- 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 quarterly meetings of OBH and SMO quality management staff to work on operational details to ensure that quality activities are consistent with the State QMS 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 QMS 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 management waiver program model:

Table 1: Quality management integrated model: oversight roles and responsibilities\*

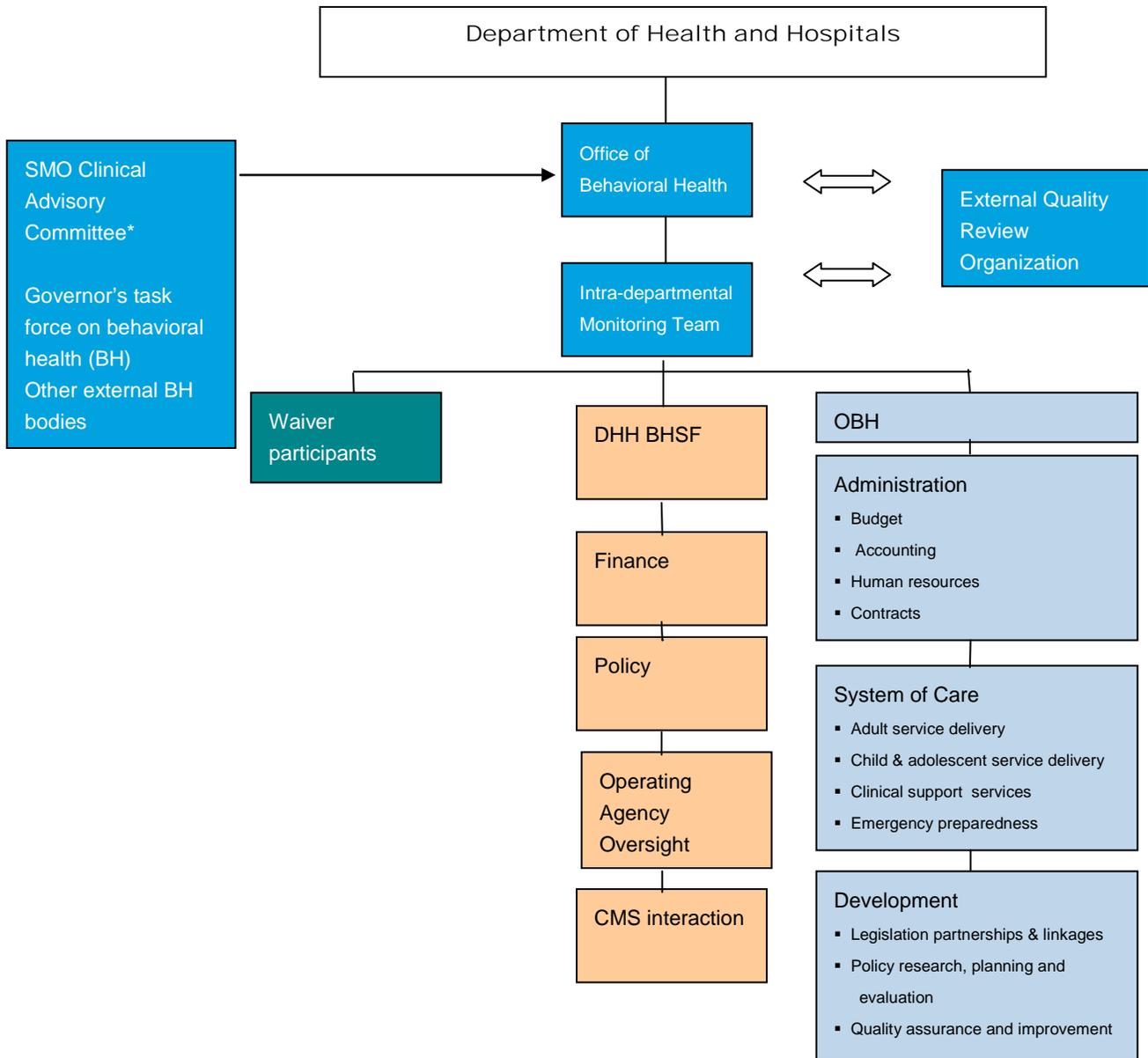
Entities	Membership	Roles and responsibilities
OBH	Lead/coordinator(s) of the SMO OBH/SMO quality management staff Others from DHH, SMO and other governmental agencies, as need arises	Oversight of QMS Development of SMO reporting requirements to IMT Communication and support of stakeholder advisory groups
IMT – Adults	BHSF  OBH  Waiver participants  SMO (Management, Finance, Operations, Quality)	OBH develops and implements quality improvement strategy (QIS). OBH then integrates the QIS with OBH quality management, SMO QAPI and waiver quality strategies Provides oversight and technical support Provides forum for best practice sharing Provides support and feedback to waiver programs for the:
IMT – CSoC	DHH BHSF  OBH  DCFS  OJJ  DOE  Waiver participants  SMO (Management, Finance, Operations, Quality)	
FCC and CFAC	Providers Advocacy Enrollees/clients State representatives SMO leadership	Reviews QMS efforts Provides forum for input from key stakeholders into quality efforts and key clinical management concerns

***\*Quality management structure is presented on the following two pages***

## Quality management structure

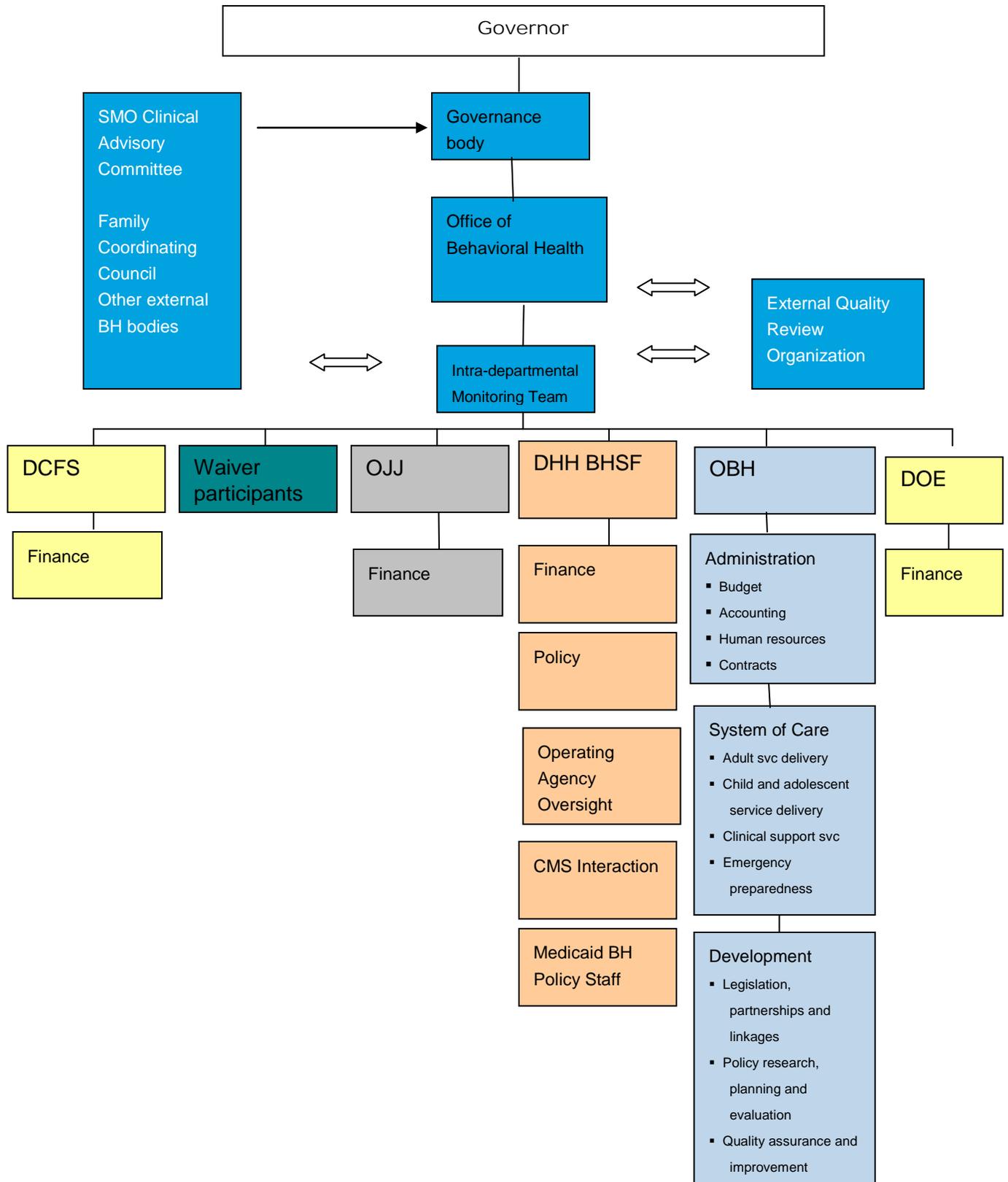
The following diagrams visually represent participants of the quality management structure for 1) adults and non-CSoC children and youth and for 2) CSoC, demonstrating levels of oversight accountabilities and communication flows. The structure is developed to maximize integration, seek opportunities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

### Quality management structure for adults and non-CSoC children



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

### Quality management structure for CSoC



## 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 Department of Health and Hospitals 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 the Office of Behavioral Health). DHH also began a complete overhaul of its mental health rehabilitation services, increasing program monitoring, requiring Mental Health Rehabilitation (MHR) provider agency accreditation, revamping service definitions and developing provider qualifications criteria. While progress was made from 2003-2005, the massive hurricanes, which struck Louisiana in 2005 and 2008, brought to light additional service gaps and system inadequacies.

To address these gaps the Office of Behavioral Health (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, 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 Office of Behavioral Health. 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 (HSD). 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 Office of Behavioral Health 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 (PIHP). 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 healthcare 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:

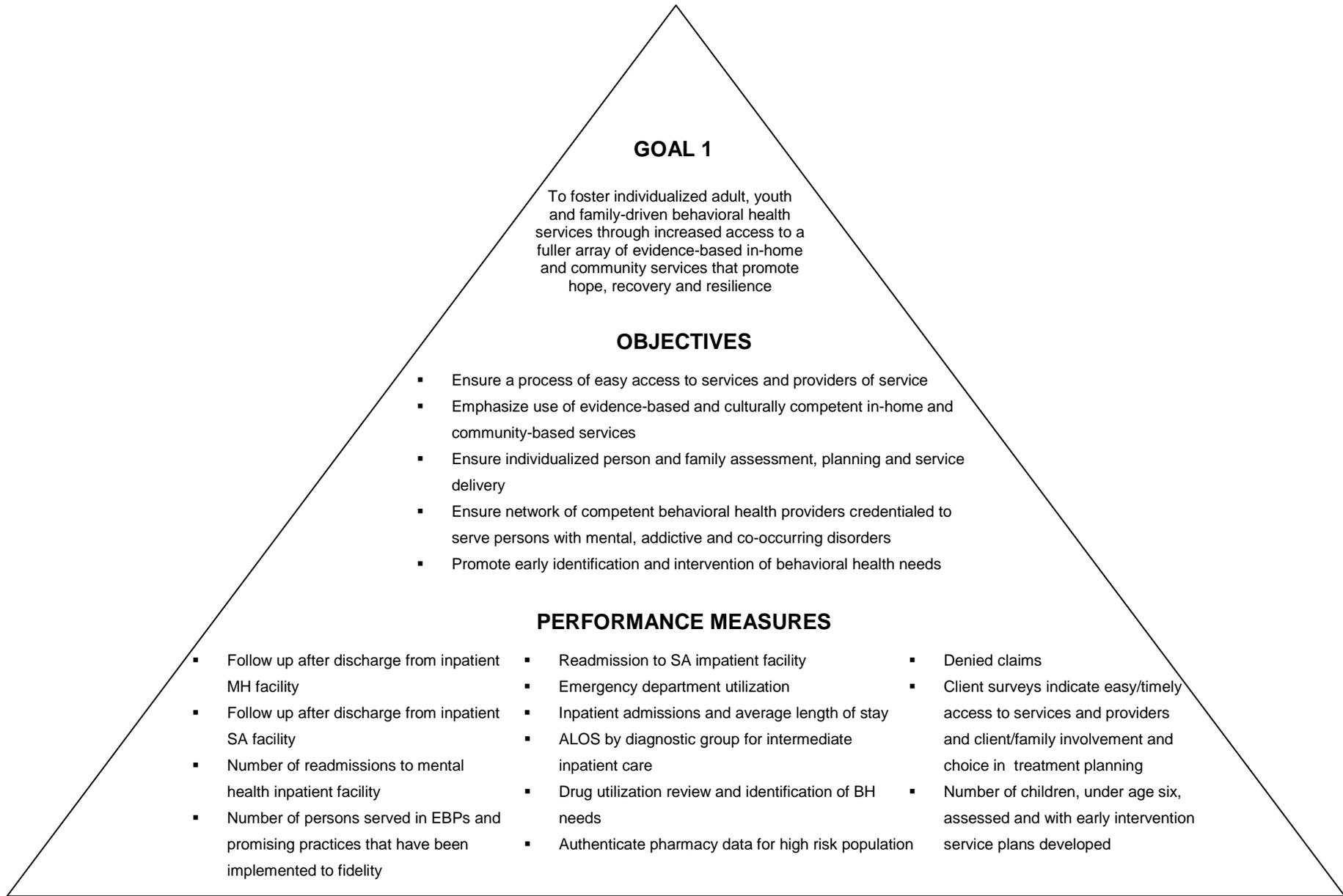
**Medicaid program goal 1:** To foster individualized adult, youth and family-driven behavioral health services through increased access to a fuller array of evidence-based in-home and community services that promote hope, recovery and resilience.

**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 BH 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



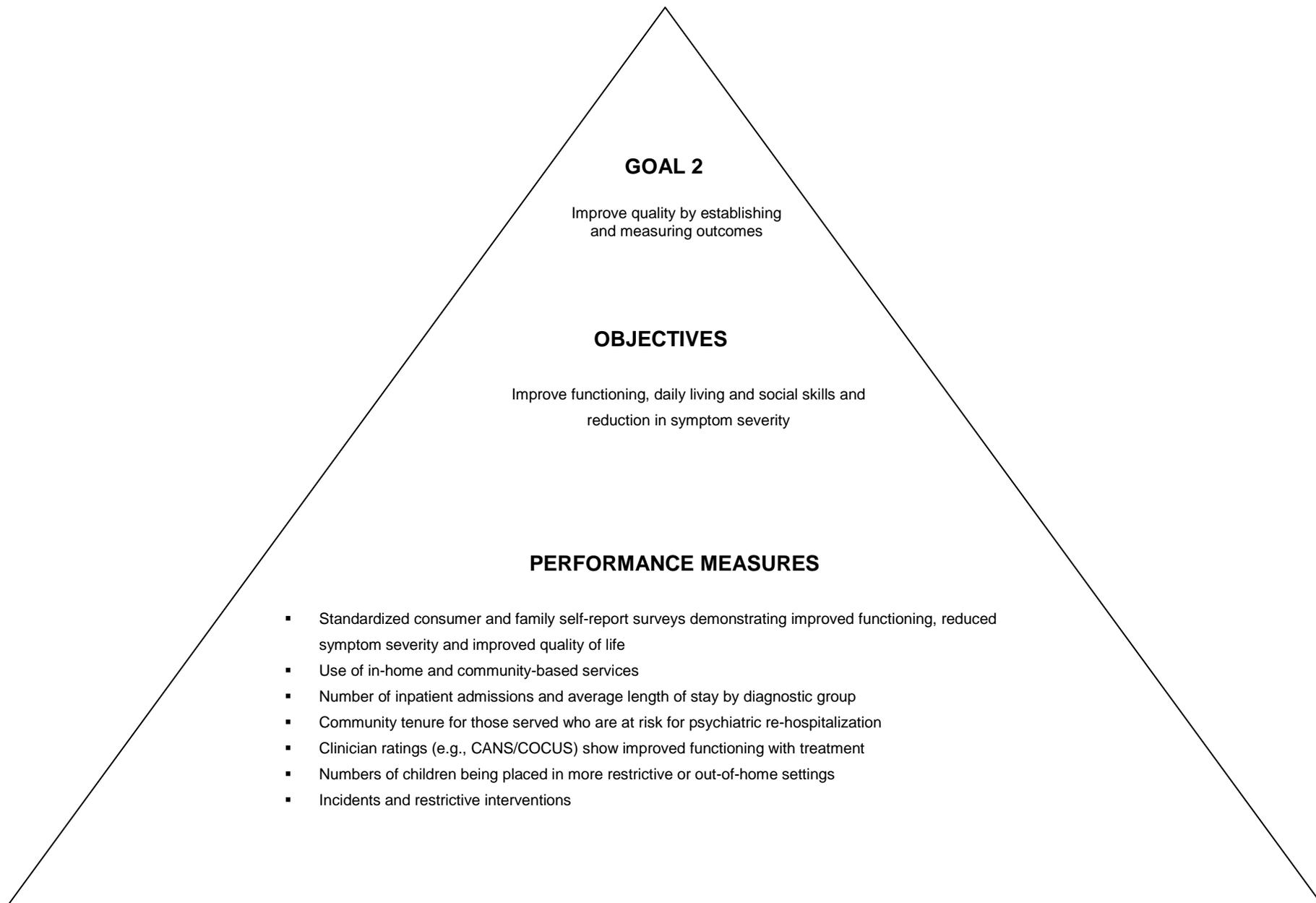
**Medicaid program goal 2:** Improve quality by establishing and measuring outcomes.

**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



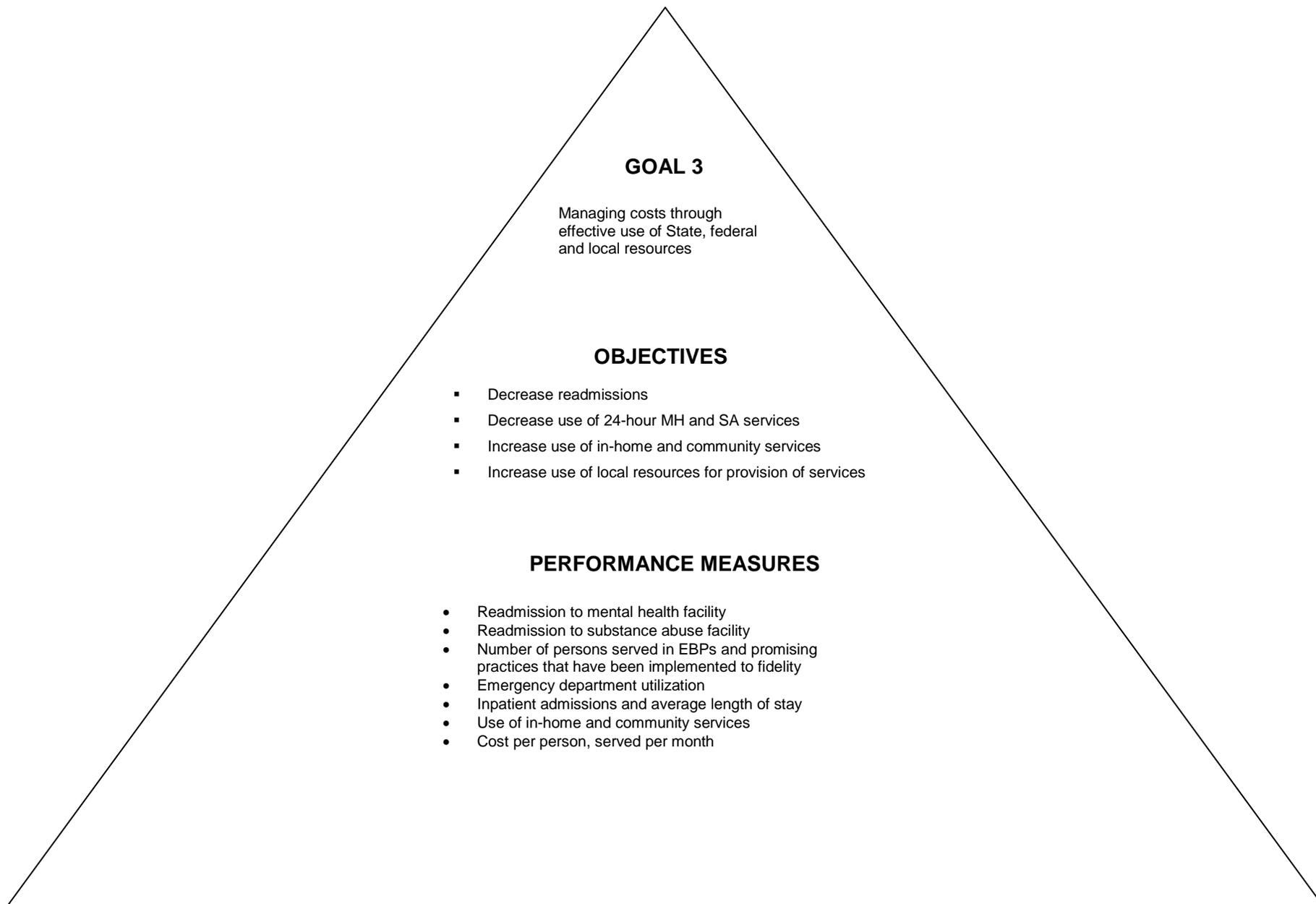
**Medicaid program goal 3:** Managing costs through effective use of State, federal and local resources.

**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



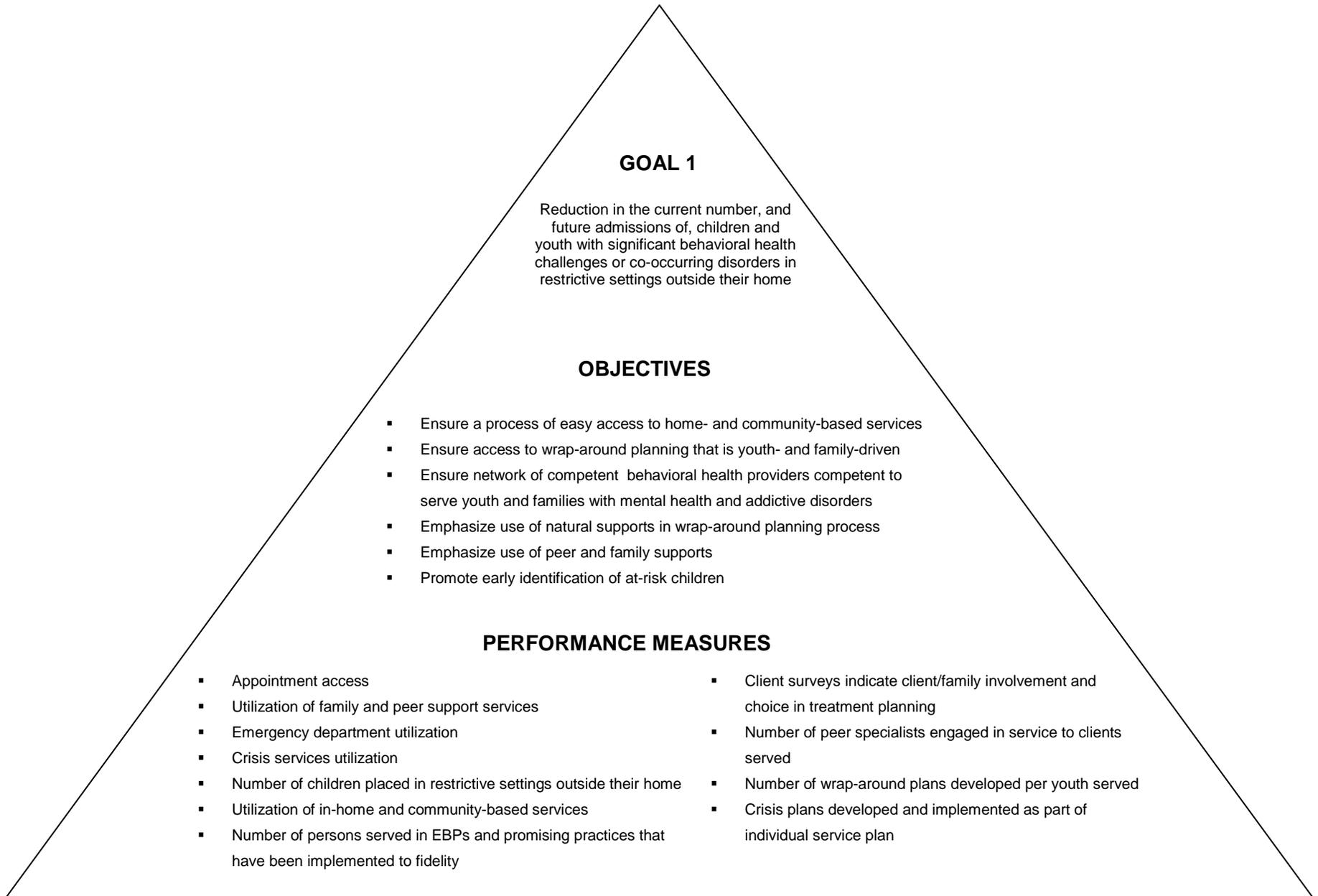
**CSoC goal 1:** Reduction in the current number, and future admissions of, children and youth with significant behavioral health challenges or COD in restrictive settings outside their home.

**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 BH 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



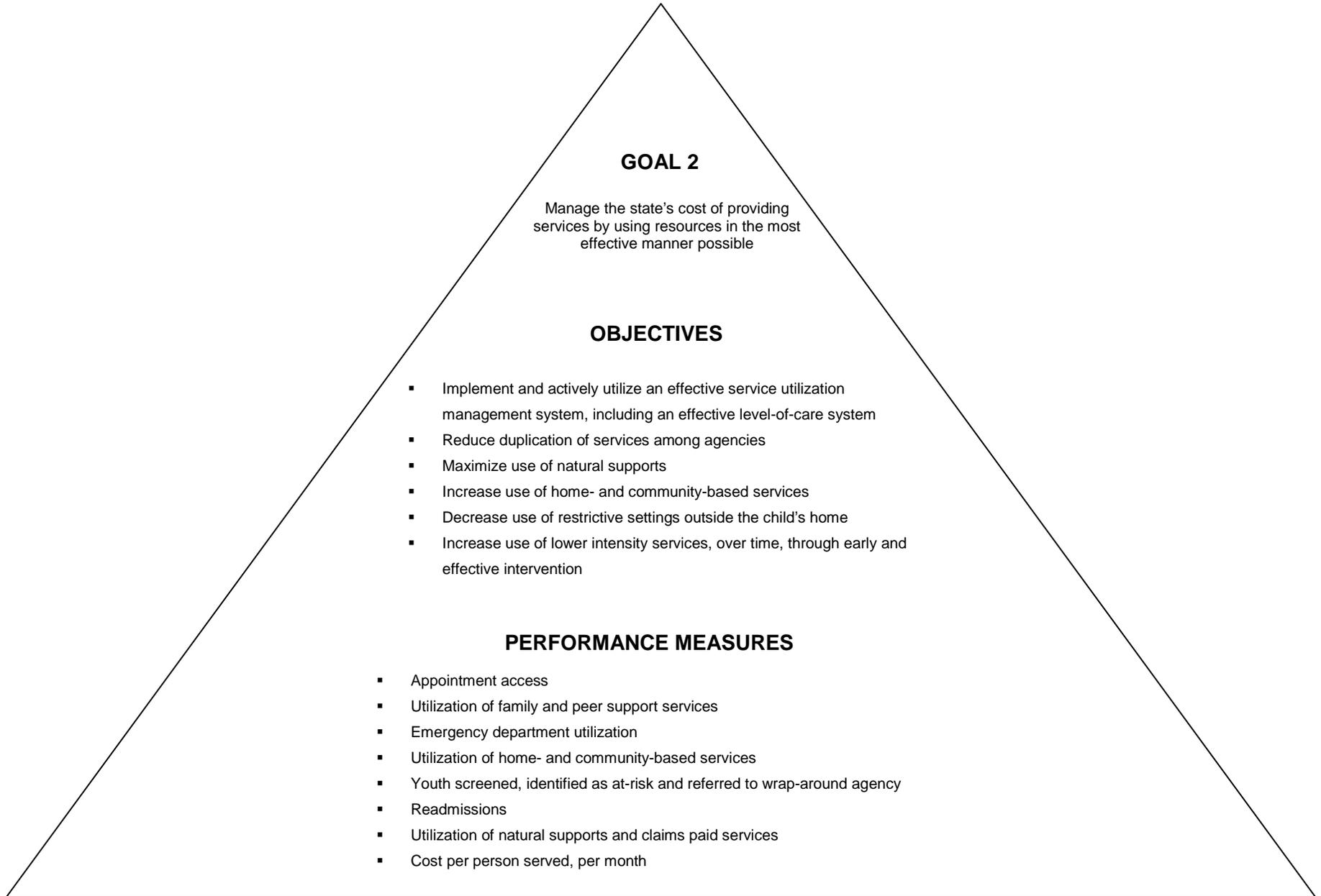
**CSoC goal 2:** Manage the State's cost of providing services by using resources in the most effective manner possible.

**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



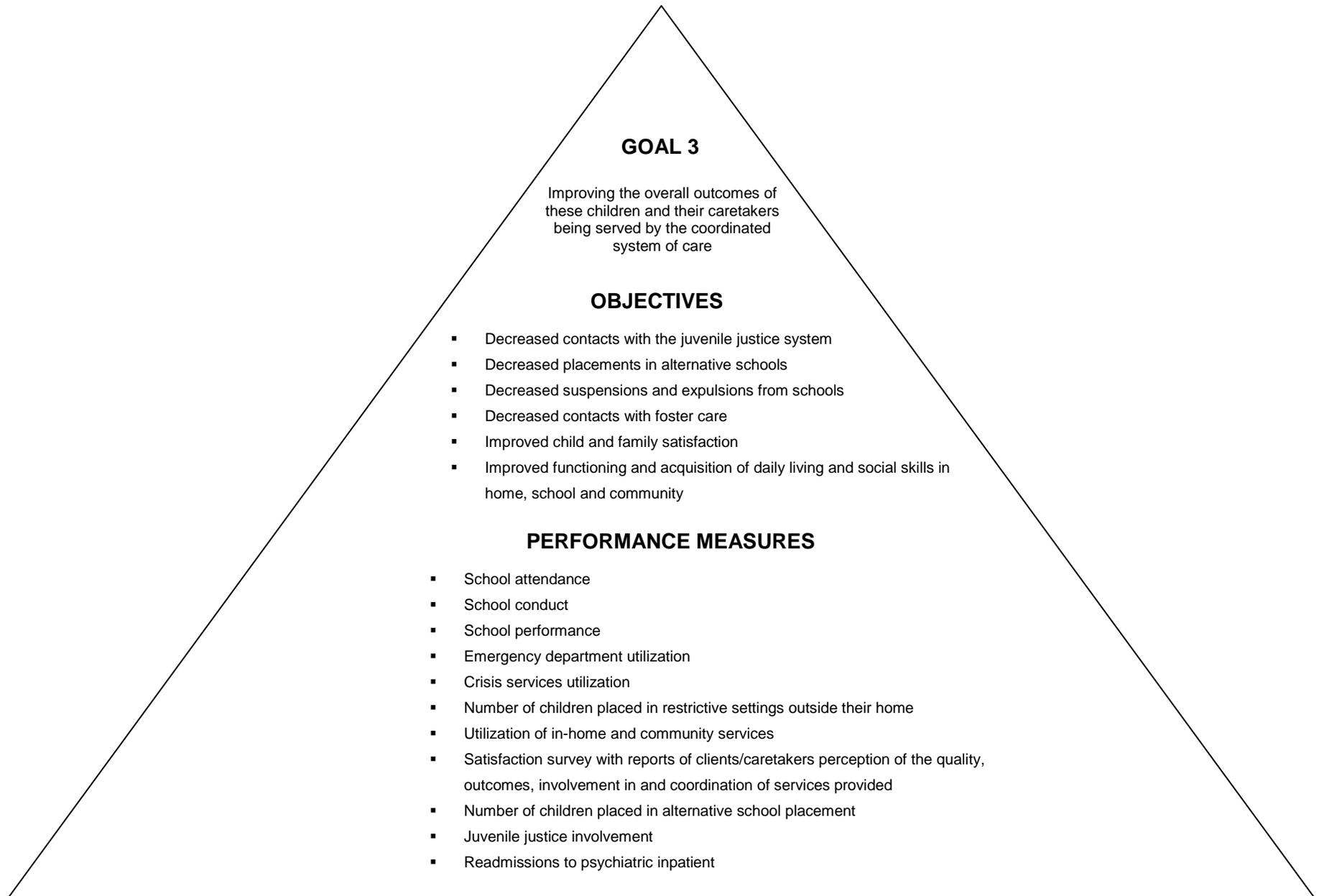
**CSoC goal 3:** Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care.

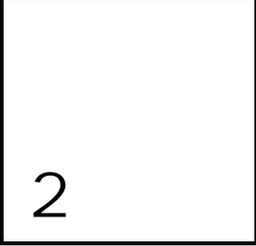
**Objectives:**

- 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



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 (SHCNs) population is defined as:

- Children and youth that have significant behavioral health challenges or CODs that are in, or at imminent risk of, out-of-home placement
- Children with behavioral health needs in contact with other child serving systems
- Adults with SPMI, IV drug user, pregnant substance abuse user, substance abusing women with dependent children or dual diagnosis

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 accord 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 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 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

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 scope of the annual EQR conducted by the State for SMOs, as mentioned in 42 CFR 438.310(b), includes: a) criteria used to select entities to perform the reviews, b) specification of activities to be performed by the EQRO, c) the circumstances in which the EQR may use other accreditation review results and d) standards for availability of review results. 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 (PHI), 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; synthesis of results compared to the standards and recommendations based on the findings. The EQRO will meet these obligations by utilizing the 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 Louisiana EQRO, 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

Optional EQRO activities conducted by the Louisiana EQRO, as mentioned in 42 CFR 438.358, may include:

- Encounter data validation

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 healthcare 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 QMS 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. 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
- CFAC 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 vs. paid services in 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

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### ***Intermediate sanctions***

The premise behind the QMS 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 management 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 not an MCO, 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 Intra-Departmental Monitoring Team.

### *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, 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*

- Corrective action plan: to be developed by the SMO at the request of OBH. (Section 1.6: Monitoring Process)
- Penalties and Sanctions (Section 13.2: Monetary Penalties; 13.3 Sanctions)
- Temporary Management (Section 13.4: Temporary Management)
- Termination (Section 12: Default and Termination)

State standards

Appointment standards	
Appointment availability	Appointment wait times
TBD	

Access standards

Access standards
<p><b>Contracted network of appropriate providers (42 CFR 438.206(b)(1))</b></p> <p>MARGARET TO PULL IN APPROPRIATE TEXT FROM WAIVER &amp; SMO CONTRACT FOR THIS SECTION</p>
<p><b>Adequate and timely second opinion (42 CFR 438.206(b)(3))</b></p>
<p><b>Adequate and timely out-of-network providers (42 CFR 438.206(b)(4) &amp; (b)(5))</b></p>
<p><b>Provider credentialing as required in regulation (42 CFR 438.206(b)(6))</b></p>

<b>Timely access (42 CFR 438.206(c)(1)(i-vi))</b> .
<b>Cultural considerations (42 CFR 438.206(c)(2))</b> <ul style="list-style-type: none"><li>▪ Transportation:</li> <li>▪ Interpreter services:</li> <li>▪ Coordination and referral to community resources:</li></ul>
Assurances of adequate capacity 438.207
<b>Documentation and assurances of adequate capacity and services (42 CFR 438.207 (b), (c))</b>



Notice Of action 438.404, 438.200, 438.228, 438.206
<b>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))</b>
<b>Notice of adverse action content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)</b>
<b>Timeframes for notice of action: (42 CFR 438.404(c)(1)) Termination, suspension or reduction of services</b>
<b>Timeframes of notice of action (42 CFR 438.404(c)(2), (3), (4), (5)&amp;(6)) Untimely service authorization decisions and service authorization requests</b>
Handling of grievances and appeals 438.406
<b>General requirements (42 CFR 438.406(a))</b>
<b>The process for appeals (42 CFR 438.406(b))</b>
<b>Resolution and notification (42 CFR 438.408(a), (b), (c))</b>  <b>Format and content of resolution notice (42 CFR 438.408(d)(e))</b>  i.
<b>Requirements for State Fair Hearings (42 CFR 438.408(f))</b>
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Information about the grievance system to providers and subcontractors. 438.414
<b>Information (42 CFR 438.414) (438.10 (g))</b>
Record keeping and reporting requirements. 438.416
Continuation of benefits while the MCO or SMO appeal and the State Fair Hearing are pending. 438.420
<b>Terminology, timely filing and continuation of benefits (42 CFR 438.420(a), (b))</b>

<b>Duration of continued or reinstated benefits (42 CFR 438.420(c))</b>
<b>Enrollee responsibility for services furnished (42 CFR 438.420(d))</b>
Effectuation of reversed appeal resolutions. 438.424
<b>Effectuation when services were not furnished (42 CFR 438.424(a))</b>
<b>Effectuation when services were furnished (42 CFR 438.424(b))</b>

***Quality assessment and performance improvement***

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## 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 sub-standard performance, interventions will be provided to SMO with timely re-evaluation processes identified. 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 QMS* 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 management 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 management 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 management 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 management 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 management 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 management 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 meets with the SMO quarterly and conducts annual on-site 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 on-site 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 quarterly 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 management 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.

QI, reporting minimally, includes statistical analysis, root cause analysis, analysis of barriers and improvement interventions. The quarterly presentations 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.

In addition, there are quarterly meetings of the OBH/SMO quality management staff to work on operational details to ensure that quality activities are consistent with QMS and contract requirements. Quarterly report results are documented in IMT meeting minutes and communicated to stakeholders and the QAPI Committee. The QAPI Committee reviews QMS 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 member newsletters.

The quality improvement strategy for the 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**

### **1. Level of care (LOC)**

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

### Participant access and eligibility

Performance measure #1	Number and/or percent of children/youth that were determined to meet LOC requirements prior to receiving waiver services.
Performance measure #2	Number and/or percent of children/youth who receive their annual LOC evaluation within twelve months of the previous LOC evaluation.
Performance measure #3	Number and/or percent of children's/youths' initial LOC determination forms/instruments that were completed, as required in the approved waiver.
Performance measure #4	Number and/or percent of LOC determinations made by a qualified evaluator.
Performance measure #5	Number and/or percent of children's/youths' semi-annual LOC determinations, where level of care criteria was applied correctly.

### **2. Service plan**

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- The state monitors service plan development in accordance with its policies and procedures.
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Services are delivered in accordance with the service plan, including in the type, scope, amount, duration and frequency specified in the service plan.
- Participants are afforded choice:
  - Between waiver services and institutional care
  - Between/among waiver services and providers

## Participant-centered planning and service delivery

Performance measure #1	Number and/or percent of children/youth 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).
Performance measure #2	Number and/or percent of children/youth reviewed whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).
Performance measure #3	Number and/or percent of plans of care that address children/youths' goals as indicated in the assessment(s).
Performance measure #4	Number and/or percent of children's/youths' plans of care that include the child/youth's and/or parent's/caregiver's signature, as specified in the approved waiver.
Performance measure #5	Number and/or percent of children's/youths' plans of care that were developed by a wraparound team.
Performance measure #6	The State requires the SMO to report results of performance measures related to the service plan to OBH and the IMT and requires corrective action, as appropriate. Corrective action is monitored at minimum quarterly by OBH and the IMT.
Performance measure #7	Number and/or percent of children/youth whose plans of care were updated within 90 days of the last update.
Performance measure #8	Number and/or percent of children/youth whose plans of care were updated when warranted by changes in the child/youth's needs.
Performance measure #9	Number and/or percent of children/youth who received services in the type, amount, duration and frequency specified in the plan of care.
Performance measure #10	Proportion of new waiver children/youth who are receiving services, according to their primary care physician (PCP), within 45 days of PCP approval.
Performance measure #11	Number and/or percent of child/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.
Performance measure #12	Proportion of children/youth reporting that their wraparound facilitator helps them know what waiver services are available.

### 3. Qualified providers

- 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.
- The state monitors non-licensed/non-certified providers to ensure adherence to waiver requirements.
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

#### Participant services

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.
Performance measure #2	Number and/or percent of waiver providers providing waiver services continuously meeting licensure, training or certification requirements while furnishing waiver services.
Performance measure #3	Number and/or percent of waiver providers providing waiver services that have an active agreement with the SMO/SMO.
Performance measure #4	Number and/or percent of non-licensed/non-certified providers of waiver services that meet training requirements.
Performance measure #5	Number and/or percent of provider trainings operated by OBH.
Performance measure #6	Number and/or percent of active providers (by provider type) meeting ongoing training requirements.

#### 4. Health and welfare

- The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

##### Participant safeguards

Performance measure: #1	Number and/or percent of reports related to the abuse, neglect or exploitation of children/youth, where an investigation was initiated within established time frames.
Performance measure: #2	Number and/or percent of children/youth who received information on how to report the suspected abuse, neglect or exploitation of children.
Performance measure: #3	Number and/or percent of children/youth who received information regarding their rights to a State Fair Hearing via the Notice of Action form.
Performance measure: #4	Number and/or percent of grievances filed by children/youth that were resolved within 14 calendar days, according to approved waiver guidelines.

#### 5. Administrative authority

- The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

##### Waiver administration and operation

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.
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).
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.

## 6. Financial accountability

- State financial oversight exists to ensure that claims are coded and paid for, in accordance with the reimbursement methodology specified in the approved waiver.

### Financial accountability

Performance measure #1	Number and/or percent of providers that have payment recouped for waiver services provided without supporting documentation.
Performance measure #2	Number and/or percent of claims verified through the SMO's/SMO's compliance audit to have paid in accordance with the child's/youth's waiver service plan.

### 1915(i) State plan monitoring

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

Requirement	Discovery activities				Remediation	
	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
Service plans address assessed needs of 1915(i) participants, are updated annually and document choice of services and providers.	<ol style="list-style-type: none"> <li>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).</li> <li>Number and/or percent of participants reviewed whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).</li> <li>Number and/or percent of plans of</li> </ol>	<ol style="list-style-type: none"> <li>2., 3., 4., 5. Record reviews, on-site; less than a 100% sample of CMEs with a 95% confidence level</li> <li>SMO reports on service plan performance measures; 100% sample</li> <li>SMO database; 100% sample</li> <li>Record reviews; 100%</li> </ol>	<ol style="list-style-type: none"> <li>2., 3., 4., 5., OBH and SMO collect, generate, aggregate and analyze</li> <li>State Medicaid Agency (BHSF) and SMO collect, generate, aggregate and analyze</li> <li>8. SMO collects and generates; OBH and SMO aggregate and analyze</li> </ol>	<ol style="list-style-type: none"> <li>Continuously and ongoing</li> <li>Quarterly</li> <li>4., 5., Continuous and ongoing</li> <li>Quarterly for corrective action plan monitoring; semi-annually reporting on measures by SMO</li> <li>Ongoing</li> <li>Quarterly data collection/generation; annual data aggregation and analysis</li> </ol>	OBH	Continuous and ongoing

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	<p>care that address participants' goals, as indicated in the assessment(s)</p> <p>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.</p> <p>5. Number and/or percent of participants' plans of care that were developed by a wraparound team.</p> <p>6. The State requires the SMO to report results of performance measures related to the service plan to OBH and the IMT and</p>	<p>sample</p> <p>9. Corporate Compliance Reports to the operating agency from the SMO; less than a 100% sample; RAND sampling methodology recommended by the Office of the Inspector General (OIG)</p> <p>10. Person centered plan record reviews, financial records; less than a 100% sample with a 95%</p>	<p>9., 10. SMO collects, generates, aggregates and analyzes</p> <p>11. OBH and SMO collect, generate, aggregate and analyze</p> <p>12. SMO collects and generates; OBH and SMO aggregate and analyze</p> <p>13 OBH and SMO collect, generate, aggregate and analyze</p>	<p>9. Quarterly data collection/generation; continuous and ongoing data aggregation and analysis</p> <p>10. Quarterly data collection/generation; semi-annual data aggregation and analysis</p> <p>11. Continuously and ongoing</p> <p>12. Quarterly data collection/generation; annual data aggregation and analysis</p> <p>13. Continuous and ongoing</p>		

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	<p>requires corrective action, as appropriate. Corrective action is monitored, at minimum, quarterly by OBH and the IMT.</p> <p>7. Number and/or percent of participants whose plans of care were updated within 90 days of the last update.</p> <p>8. Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs.</p> <p>9. Number and/or</p>	<p>confidence level</p> <p>11. Record reviews, on-site; less than a 100% sample of wrap-around agencies, with a 95% confidence level</p> <p>12. - 13. Record reviews, on-site; less than a 100% sample of wraparound agencies, with a 95% confidence level</p>				

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	participants who received services in the type, amount, duration and frequency specified in the plan of care. 10. Proportion of new 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					

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	<p>participants reporting their care coordinator helps them to know what waiver services are available.</p> <p>13. 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.</p>					
Providers meet required qualifications.	<p>1. Number and/or percent of waiver providers providing waiver services initially meeting licensure requirements prior to</p>	<p>1., 2. DHH and the OBH; 100% sample</p> <p>3. OBH contracts with a SMO to enroll qualified</p>	<p>1., 2. DHH and OBH collect, generate, aggregate and analyze.</p> <p>3. OBH collects,</p>	<p>1., 2., 3. Continuous and ongoing</p> <p>4. Monthly</p> <p>5. Quarterly</p> <p>6. Annually</p>	OBH	Annually

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	furnishing waiver services. 2. Number and/or percent of waiver providers providing waiver services continuously meeting licensure 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	providers and pay claims; 100% sample. 4., 5., 6. Training verification records; 100% sample.	generates, aggregates and analyzes. 4., 5. Training contractor collects and generates, OBH aggregates and analyzes. 6. SMO collects and generates; OBH aggregates and analyzes.			

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	trainings operated by OBH. 6. Number and/or percent of active providers (by provider type) meeting ongoing 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	1., 2. & 3. Reports to State Medicaid Agency (BHSF) on delegated administrative functions; 100% sample size.	1., 2. & 3. OBH collects, generates, aggregates and analyzes.	1., 2. & 3. Monthly	OBH , SMO	Monthly

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
	financial reports approved by the State Medicaid Agency (BHSF) prior to implementation by the operating agency (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	1. Number and/or percent of providers that have payment recouped for waiver services without supporting documentation. 2. Number and/or	1. Routine Medicaid claims verification audits; Representative sample of wrap-around	1. SMO collects, generates, aggregates and analyzes. 2. SMO collects and generates;	1. Continuous and ongoing. 2. Quarterly data collection and generation; continuous and	SMO	Continuous and ongoing

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	percent of claims verified through the SMO's compliance audit to have paid in accordance with the participant's waiver service plan.	agencies with a 95% confidence interval. 2. SMO's compliance report; less than a 100% sample, with the RAND sampling methodology recommended by the OIG.	OBH and SMO aggregate and analyze.	ongoing data aggregation and analysis.		
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of	1. Number and/or percent of reports related to the abuse, neglect, or exploitation of participants where an investigation was initiated within established time frames. 2. Number and/or percent of participants who	1., 2., 100% sample, OBH performance monitoring 3. A sample of wrap-around agencies with 95% confidence; on-site record reviews	1. OBH collects, generates, aggregates and analyzes 2. SMO collects and generates; OBH aggregates and analyzes 3. OBH and SMO collect,	1. Monthly 2., 3. Continuously and Ongoing 4. Weekly 5. Monthly	OBH	Monthly

Discovery activities					Remediation	
Requirement	Discovery evidence <i>(Performance measures)</i>	Discovery activity <i>(Source of data and sample size)</i>	Monitoring responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation responsibilities <i>(Who corrects, analyzes and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>of analysis and aggregation</i>
restraints.	<p>received information on how to report the suspected abuse, neglect or exploitation of children.</p> <p>3. Number and/or percent of participants who received information regarding their rights to a State Fair Hearing via the Notice of Action form.</p> <p>4. Number and/or percent of grievances filed by participants that were resolved within 14 calendar days, according to approved waiver guidelines.</p> <p>5. Number and/or percent of allegations of abuse, neglect or exploitation investigated that were later substantiated.</p>	<p>4. 100% review, provider performance monitoring.</p> <p>5. 100% review, OBH abuse, neglect or exploitation database.</p>	<p>generate, aggregate and analyze.</p> <p>4. SMO collects and generates; OBH aggregates and analyzes.</p> <p>5. OBH collects generates, aggregates and analyzes.</p>			

**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												

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
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 plan							X	X				
Ombudsman												
On-site review		X			X	X			X	X	X	
Performance improvement							X		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
projects												
Performance measures								X		X		X
Periodic comparison of # 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 (BBA) regulations and the approved waivers.

The IMT meets quarterly 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 management 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, service utilization measures; making recommendations and providing technical assistance. 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, NC G.S. 122C-112.1. The IMT is composed of representatives from:

- OBH
  - BHSF
  - OJJ
  - DCFS
  - DOE
  - Waiver participants
  - SMO
- a. \_\_\_\_\_ Accreditation for Non-duplication.
- b.  Accreditation for participation (i.e., as prerequisite to be Medicaid plan)
- National Committee on Quality Assurance
  - \_\_\_\_\_ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - \_\_\_\_\_ Accreditation Association for Ambulatory Health Care (AAAHC)
  - 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.  Consumer self-report data
- Consumer Assessment of Health Plan Study (CAHPS) (please identify which one(s))
- 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 the Substance Abuse and Mental Health Services Administration (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 QMS. 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

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.  Data analysis (non-claims)

- Denials of referral requests
- Disenrollment requests by enrollee
  - From plan
  - From PCP within plan
- 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 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:
  - Grievance
  - 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
  - Grievance
  - 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 quality management (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.  Geographic mapping of provider network

- Applicable program: SMO
- Personnel responsible: SMO
- Detailed description: Through geographic mapping, distribution of provider types across the state are 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.  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.  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.  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.  On-site review

**On-site 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.  Performance improvement projects

Clinical

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.  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 national outcomes measures (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, 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.  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 (LCSWs) 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.  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 utilization management (UM) data, on-site review results and claims data review. The designated social and rehabilitation services (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- and under-utilization reviews through the use of outlier reports and regular utilization reports and analyses.
- 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 an annual basis.
- 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- 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. The data are utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. 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 (MFCU) via the State Medicaid Agency.

## Health information technology

In accordance with 42 CFR 438.242, the SMO must operate a management information system 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, managed care organizations

(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- 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.

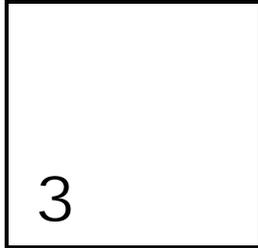
As required by CFR 438.204(f), the Medicaid management information system (MMIS) will be used to monitor the encounter data submitted by the SMO. The MMIS stores and utilizes client eligibility records, managed care enrollment records, premium collection records and provider eligibility records for:

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

A surveillance and utilization review system within the MMIS produces reports based either on claims or encounter data or both. Information identified in the unit will be **XXXXXXX**.

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.



## 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 participants/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 assure improvement is maintained, may be placed on an alternative year remeasurement 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 remeasurement year
- Year two: Interventions implemented and results reported (reported results may not include full impact of interventions based upon timing issues)
- Year three: Remeasurement and ongoing improvement with adjustment in interventions as appropriate
- Year four: Remeasurement 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.

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## 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 QA/PI, 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).
- QA/PI committee minutes.

### ***Monthly reports***

- Coordination of benefits

### ***Quarterly reports***

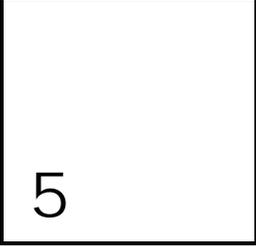
- Grievance and appeal reports
- Fiscal monitoring report (within 60 days after the end of each SFY quarter)
  - Analysis of revenues and expenses
  - Claims processing report
  - Enrollment table report (quarterly report due 60 days, following end of the quarter)
  - Incurred but not reported (IBNR)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

## ***Annual reports***

- A revised and updated QA/PI 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
  - OMB 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 QMS will provide a more detailed overall analysis and assessment of the effectiveness of the QMS 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 QMS initiative results
  - Best practices and lessons learned with resultant changes to the following years strategy
- The biannual 1915(b) waiver includes a summary of each strategy outlined in the 1915(b) waiver

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## 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.

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