U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

# Environment Scan of MLTSS Quality Requirements in MCO Contracts

September 2013

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This report was prepared under contract #HHSP23337003T between HHS's ASPE/DALTCP and Truven Health Analytics, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the ASPE Project Officer, Pamela Doty, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Pamela.Doty@hhs.gov.

# ENVIRONMENT SCAN OF MLTSS QUALITY REQUIREMENTS IN MCO CONTRACTS

**Pat Rivard**
**Beth Jackson**
**Jason Rachel**
**Julie Seibert**
**Taylor Whitworth**

Truven Health Analytics

September 2013

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHSP23337003T

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# LIST OF EXHIBITS

# ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

| | |
|---|---|
| ACAP | Pennsylvania Adult Community Autism Program |
| ACO | Accountable Care Organization |
| ADA | Americans with Disabilities Act |
| ADL | Activity of Daily Living |
| AHCCCS | Arizona Health Care Cost Containment System |
| AIDS | Acquired Immunodeficiency Syndrome |
| ALF | Assisted Living Facility |
| ALTCS | Arizona Long-Term Care System |
| ALTSD | New Mexico Aging and Long-Term Services Department |
| ASAM | American Society of Addiction Medicine |
| ASAP | Aging Services Access Points |
| BMI | Body Mass Index |
| CAHPS | Consumer Assessment Health Care Providers and Systems |
| CATS | Client Assessment and Tracking System |
| CCIP | Chronic Care Improvement Program |
| CCNC | Community Care of North Carolina |
| CFR | Code of Federal Regulations |
| CHCQM | Certified in Health Care Quality and Management |
| CHF | Congestive Heart Failure |
| CI | Critical Incident |
| CIO | Chief Information Officer |
| CMO | Chief Medical Officer |
| CMS | HHS Centers for Medicare and Medicaid Services |
| CoLTS | Coordination of Long-Term Services |
| COPD | Chronic Obstructed Pulmonary Disease |
| CORE | Consolidated Outreach and Risk Evaluation |
| CPHQ | Certified Professional in Healthcare Quality |
| CQI | Continuous Quality Improvement |
| DD | Developmental Disability(ies) or Developmentally Disabled |
| DHHS | North Carolina Department of Health and Human Services |
| DM | Disease Management |
| DMA | North Carolina Division of Medical Assistance |
| DMH/DD/SAS | North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services |
| DON | Determination of Need |
| DRG | Diagnosis-Related Group |

| | |
|---|---|
| DSHP-Plus | Delaware Diamond State Health Plan Plus |
| DSHS | Washington Department of Social and Health Services |
| DTR | Denial, Termination, and Reduction |
| EOHHS | Massachusetts Executive Office of Health and Human Services |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment Program |
| EQRO | External Quality Review Organization |
| ER | Emergency Room |
| ESR | Enrollee Service Representative |
| EVV | Electronic Visit Verification |
| FE | Frail Elderly |
| FFS | Fee-For-Service |
| FTE | Full-Time Equivalent |
| GSSC | Geriatric Support Services Coordinator |
| HCBS | Home and Community-Based Services |
| HDL | High-Density Lipoprotein |
| HEDIS | Health Effectiveness Data and Information Set |
| HFA | Health and Functional Assessment |
| HFS | Illinois Department of Healthcare and Family Services |
| HHSC | Texas Health and Human Services Commission |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIV | Human Immunodeficiency Virus |
| HOS | Health Outcomes Survey |
| HRQ | Health Risk Questionnaire |
| HSD | New Mexico Human Services Department |
| HSW | Habilitation Supports Waiver |
| ICSP | Illinois Integrated Care System Partnership |
| ICT | Integrated Care Team |
| IDD | Intellectual and Developmental Disabilities |
| IDT | Interdisciplinary Team |
| IMT | Intra-departmental Monitoring Team |
| ISHCN | Individuals with Special Health Care Needs |
| ISP | Individualized Service Plan |
| IT | Information Technology |
| KCPC | Kansas Client Placement Criteria |
| KDHE | Kansas Department of Health and Environment |
| LDL | Low-Density Lipoprotein |
| LEIE | List of Excluded Individuals/Entities |
| LME | Local Management Entity |
| LOC | Level of Care |

| | |
|---|---|
| LTSS | Long-Term Services and Supports |
| MAP | New York Medicaid Advantage Plus |
| MCO | Managed Care Organization |
| MCP | Member-Centered Plan |
| MDCH | Michigan Department of Community Health |
| MFP | Money-Follows-the-Person |
| MH | Mental Health |
| MHSIP | Mental Health Statistics Improvement Program |
| MI | Mentally Ill |
| MIS | Management Information System |
| MLTSS | Managed LTSS |
| MSC+ | Minnesota Senior Care Plus |
| MSHO | Minnesota Senior Health Option |
| NAHQ | National Association for Health Care Quality |
| NCQA | National Committee on Quality Assurance |
| NF | Nursing Facility |
| NOMS | National Outcome Measurement System |
| OBRA | Omnibus Budget Reconciliation Act |
| P4P | Pay-For-Performance |
| PCP | Primary Care Provider or Physician |
| PCT | Primary Care Team |
| PD | Physical Disability |
| PERS | Personal Emergency Response System |
| PIHP | Pre-paid Inpatient Health Plan |
| PIP | Performance Improvement Project |
| POC | Plan of Care |
| QA | Quality Assurance |
| QAPIP | Quality Assessment and Performance Improvement Plan |
| QEHO | Quality, Evaluation, and Health Outcomes |
| QExA | Hawaii QUEST Expanded Access |
| QI | Quality Improvement |
| QIC | Quality Improvement Council |
| QIP | Quality Improvement Project |
| QM | Quality Management |
| RFP | Request for Proposal |
| RN | Registered Nurse |
| SA | Substance Abuse |
| SAAM | Semi-Annual Assessment of Member |
| SAS | Substance Abuse Services |

| | |
|---|---|
| SCO | Senior Care Organization |
| SDOH | New York State Department of Health |
| SED | Serious Emotional Disturbance |
| SNF | Skilled Nursing Facility |
| SNP | Special Needs Plan |
| SP | Service Plan |
| SPMI | Serious and Persistent Mental Illness |
| SSI | Supplemental Security Income |
| SUD | Substance Use Disorder |
| TBI | Traumatic Brain Injury |
| TCAD | Tennessee Commission on Aging and Disability |
| TQM | Total Quality Management |
| UAT | Uniform Assessment Tool |
| UM | Utilization Management |
| WMIP | Washington Medicaid Integration Partnership |

# EXECUTIVE SUMMARY

Contracts with managed care organizations (MCOs) in 17 states were reviewed. The scan of managed long-term services and supports (MLTSS) quality requirements revealed wide diversity in some instances and in others more convergence. Also, whereas contracts may require the same quality elements, in one state the requirement may be very specific and prescriptive whereas in another state the details of implementing the requirement may be left to MCO discretion. Finally, quality elements that are not contractually required may, in some states, nevertheless be standard practice.

## 1. Quality Management Infrastructure Requirements

a. Staffing Requirements for Quality Oversight and Reporting. Although 16 of the 17 contracts reviewed include language related to staffing requirements for quality oversight and monitoring, there is a wide variety of requirements.

b. Staffing and Processes for Provider Monitoring and Reporting Requirements. All 17 states include language in their contracts related to provider monitoring. Most require that MCOs engage in credentialing and re-credentialing of providers.

c. Staffing Requirements and Processes for Care Coordinator Monitoring and Reporting. Eleven of the 17 states include language in their contracts related to care coordinator staffing and/or processes for oversight of care coordinators.

d. Information Technology Requirements in Support of Quality Monitoring and Reporting. All 17 states include language in their contracts related to information technology requirements. However, several contracts are generic with regard to information technology and the functions it must support.

e. Critical Incidents Reporting/Investigation Requirements. Fourteen states include language in their contracts that require MCOs to have critical incident reporting processes and many of these states enumerate the actual critical incidents that they must incorporate into their systems. In addition, some states require the MCO to contact the state in the event of certain critical incidents (e.g., deaths, abuse, neglect, exploitation).

f. Required Mechanisms for Monitoring Receipt of Long-Term Services and Supports (LTSS). Ten states include contract language related to mechanisms for monitoring receipt of community LTSS and associated

reporting requirements. There is a fair amount of variability in these monitoring mechanisms from the real-time Electronic Verification System (where the MCO is alerted to late receipt of services in a member's service plan) to retrospective verification of service receipt for which a provider has billed.

g. Required Mechanisms for Handling Complaints, Grievances, Appeals, and Associated Reporting. Sixteen states include language in their contracts related to MCO mechanisms for handling complaints, grievances, and appeals. This is not surprising given that grievances and appeals are a fundamental Medicaid requirement and spelled out in detail in the federal Medicaid managed care regulations. However, there is variability in how this requirement is delegated to the MCOs.

## 2. Required LTSS Performance Measures

Thirteen states include language related to LTSS performance measures in their MCO contracts. Some measures focus on the processes for response time to respond to referrals, timeliness of receipt of covered services, timeliness of care plan implementation, process for handling critical incidents, and process for coordination of services.

Several contracts also specify outcomes related to community retention rate, rate of preventable hospital admissions, rates of nursing facility and chronic hospital admission.

When a contract does not enumerate performance measures, it cannot be assumed that the MCO has no responsibility for reporting measures and using them as barometers for performance and improvement. While no performance measures may be specifically articulated in the contract, the quality reports that the MCO is required to produce may require inclusion of information that measures the MCO's performance in multiple domains.

## 3. Required Performance Improvement Projects (PIPs)

All 17 states require that MCOs carry out 2-3 PIPs that focus on clinical and non-clinical areas. Much of the PIP language in many contracts is taken verbatim from Code of Federal Regulations (CFR) 438. Accordingly, the contractual language is often vague enough that it is difficult to tell whether there are any LTSS-related PIP requirements. Out of the 17 contracts, only two clearly articulated LTSS-specific PIP requirements.

## 4. Required Involvement with the External Quality Review Organization (EQRO)

All 17 states include language regarding the role of an EQRO which includes validation of performance measure data and PIP--also expected given the CFR 438 requirement for an external quality review. Often states have used verbatim language from CFR 438. Most include language that requires MCOs to cooperate with the EQRO.

## 5. Care Coordination Requirements

a. Assessment Requirements. Fourteen states require that MCOs use either a state assessment form or a form approved by the state to determine member needs and/or level of care eligibility for the LTSS program.

b. Care Coordinator/Member Ratio Requirements. Only six states include language in their MCO contracts that establish caseload ratios.

c. Frequency and Nature of Member Monitoring Requirements. One of the major functions of most care coordination is to monitor the service delivery to and well-being of members. Ten state contracts specify expectations about how these functions will be carried out.

d. LTSS-Acute Care Coordination Requirements. Regardless of whether a program offers both managed medical care and LTSS or just MLTSS, coordination of medical and LTSS is in the member's best interest. Indeed coordination is one of the hallmarks of managed care. Nearly all the contracts (16) include clauses requiring such coordination.

e. Risk Assessment and Mitigation Requirements. Nine states include requirements related to risk assessment and mitigation in their MCO contracts but they vary in the type of risk focused upon and whether mitigation requirements are specified.

## 6. Ombudsman--Like Functions Requirements

Eight states address either the availability of an Ombudsman program or require the MCO to fulfill some ombudsman-like functions (e.g., member advocacy) in their contracts.

## 7. Financial Incentives for Performance

Nine states include financial incentives for performance in their contracts with MCOs.

## 8. Experience of Care/Satisfaction Feedback Requirements

Nine states include language in their contracts related to experience of care/satisfaction surveys or focus groups. That said, language in the contracts was not always specific enough to determine if the required feedback mechanism included a focus on LTSS as most of the examples below exhibit. Some states may assume this responsibility or employ an independent vendor for this purpose rather than delegate this activity to MCOs. Thus it should not be assumed that if such a requirement is not included in the MCOs contract that the state does not have a LTSS feedback mechanism in place.

## 9. Quality Improvement Reports

Sixteen states include language in their MCO contacts related to LTSS Quality Reports. Some states require quarterly reports and others require annual reports.

# I. INTRODUCTION

A growing number of states have now decided to expand their managed care programs to encompass Long-Term Services and Supports (LTSS). From 2004 to 2012, the number of states with Medicaid managed LTSS (MLTSS) programs doubled from eight to 16, and ten more states are projected to implement MLTSS programs by 2014.[1] With this move comes a major change in roles for quality oversight with states placing substantial responsibility for monitoring and quality reporting on the managed care organizations (MCO) with which they contract. One avenue for understanding how states are delegating these responsibilities is through an environmental scan of the contracts that states have negotiated with MCOs.

Between June and August 2013, Truven Health Analytics conducted an environmental scan of 17 state contracts with MCOs for Medicaid MLTSS programs. The focus of this scan is on the quality requirements specified in these contracts. The scan explores required components of quality in these contracts spanning:

- MCO quality management (QM) infrastructure (including staffing);
- Provider monitoring;
- Mechanisms for tracking receipt of services;
- Critical incident reporting;
- Risk assessment and mitigation;
- Performance measure reporting;
- Performance improvement projects (PIPs);
- MCO involvement in External Quality Review Organization (EQRO) activities;
- Care coordination requirements related to maximizing the health and welfare of members;
- Ombudsman-like functions that the MCO is required to provide to members;
- Quality-related financial incentives;
- Member feedback mechanisms (Experience of Care, satisfaction surveys, focus groups);
- Quality reports.

In the body of this report, we describe how frequently the various quality elements appear in the contracts, as well as some similarities and differences in quality requirements.

[1] Saucier, P., J. Kasten, B. Burwell and L. Gold. 2012. *The Growth of Managed Long Term Services and Supports (MLTSS) Programs: A 2012 Update*. Centers for Medicare and Medicaid Services. http://www.medicaid/gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf. Accessed August 8, 2013.

The Appendices at the end of the report provides individual summaries for each contract reviewed. In developing these summaries, we imported language from the contracts when practical. As such, much of the text in these entries has a legalistic flavor. In some instances, the contract language might be interpreted to invoke the quality requirement of interest, but unless it was clearly articulated as required, we did not represent it as required. In many instances (as practical) we have maintained fidelity to the contract language so that the reader may make his/her own determination.

# II. SCAN METHODOLOGY

Our source data for the scan were the standard contracts that states use to engage MCOs to provide MLTSS in their Medicaid programs. These documents are available on state websites and other public domains.

In developing the data collection tool for this exercise, we relied upon three main sources for identifying key features of quality design and management for MLTSS: (1) the Centers for Medicare and Medicaid Services' (CMS') recently released guidance to the states on the design of Medicaid 1115 Demonstration and 1915(b) Waivers as vehicles for Medicaid MLTSS programs;[2] (2) quality requirements associated with the 1915(c) Home and Community-Based Services (HCBS) Waiver program[3] which are often imbedded within the Terms and Conditions to which states seeking approval of 1115 waivers must agree, and which are required when states operate "combo" waivers (typically using 1915(c) waiver authority with 1915(a) or (b) waiver authority); and (3) quality-related federal requirements specified in the regulations that govern Medicaid managed care (Code of Federal Regulations [CFR] 438).[4]

As many of the contracts are very large (running into hundreds of pages), it would have been too labor intensive to read through the entirety of each contract. Instead, we relied on the contracts' tables of content to locate contract requirements of interest. We also employed document search functions using a range of appropriate terminology for each quality element in the scan.

The scan included MCO contracts developed by the following 17 states for their MLTSS Programs.

| | |
|---|---|
| Arizona | Arizona Long-Term Care System (ALTCS) |
| Delaware | Diamond State Health Plan-Plus (DSHP-Plus) |
| Florida | Long-Term Care Community Diversion Pilot Project |
| Hawaii | QUEST Expanded Access (QExA) |
| Illinois | Integrated Care System Program (ICSP) |
| Kansas | KanCare |
| Massachusetts | Massachusetts Senior Care Options |
| Michigan | Medicaid Managed Specialty Supports and Services |

[2] Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, 2013. *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf. Access August 30, 2013.

[3] Medicaid 1915(c) HCBS Waiver quality requirements are specified in various appendices of Version 3.5 of the waiver application: http://157.199.113.99/WMS/faces/portal.jsp. Accessed August 30, 2013.

[4] Medicaid Managed Care regulations may be found in CFR 438: http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol4-part438/content-detail.html. Accessed August 30, 2013.

| | |
|---|---|
| Minnesota | Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO) |
| New Mexico | Coordination of Long-Term Services (CoLTS) |
| New York | Medicaid Advantage Plus (MAP) |
| North Carolina | MH/DD/SAS Health Plan Waiver |
| Pennsylvania | Adult Community Autism Program (ACAP) |
| Tennessee | TennCare CHOICES in LTSS |
| Texas | STAR+PLUS |
| Washington | Washington Medicaid Integration Partnership (WMIP) |
| Wisconsin | Family Care |

# III. SCAN HIGHLIGHTS

Below we highlight what the scan revealed about the quality requirements MLTSS states choose to include in contracts with MCOs. In some instances there is wide diversity in what the contracts require and in others more convergence. Also, contracts may require the same quality element but one may be very prescriptive and specific about how the requirement is to be carried out and yet another may leave the details of implementation to the MCO discretion. The highlights below provide the reader with a flavor for these similarities and differences.

Presumably, the quality requirements imbedded in the contracts are those that the state deems critical for the delivery of high quality services and for maximizing the health and well-being of members served by these entities. However, we caution that the state summaries do not necessarily present a full description of the QM requirements in each program. The summaries and our review of them present only what appears in the contracts. State practices may vary to the extent to which contract quality requirements wholly represent quality practices in each state.

The matrix represented in Exhibit 1 provides a high-level overview of the types of quality requirements found in each state's MCO MLTSS contract.

## 1. Quality Management Infrastructure Requirements

a. Staffing Requirements for Quality Oversight and Reporting. Although 16 of the 17 contracts reviewed include language related to staffing requirements for quality oversight and monitoring, there is a wide variety of requirements.

- In Arizona, MCOs must ensure that the QM/Quality Improvement (QI) Unit within the organizational structure is separate and distinct from any other units or departments.
- In Hawaii and Illinois, the MCO Medical Directors are responsible for overseeing MCO quality programs.
- Tennessee MCOs are required to have a quality committee that oversees the quality functions and a staff person responsible for all quality activities. The quality committee is required to notify the state of meetings in a timely fashion and to the extent allowed by law; the state may attend the QM/QI committee meetings.
- Wisconsin MCOs are required to have a governing board accountable for the QM program and a manager responsible for implementation of the QM plan with authority to deploy the resources committed to it.
- Texas MCOs must designate key executive staff with responsibility for QI and must notify the state if there is any change in this key position.

b. Staffing and Processes for Provider Monitoring and Reporting Requirements. All 17 states include language in their contracts related to provider monitoring. Most require that MCOs engage in credentialing and re-credentialing of providers.

- MCOs in Minnesota must submit annual reports to the state that include a complete list of participating providers with name, specialty, and address.
- New Mexico requires MCOs to have a credentialing committee to make recommendations regarding credentialing decisions.
- North Carolina requires MCOs to measure the performance of providers and conduct peer review activities such as identification of practices that do not meet plan standards, recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by providers.

c. Staffing Requirements and Processes for Care Coordinator Monitoring and Reporting. Eleven of the 17 states include language in their contracts related to care coordinator staffing and/or processes for oversight of care coordinators.

- Wisconsin MCOs are required to conduct ongoing program reviews and collect evidence to demonstrate that appropriate risk assessments are performed on a timely basis, member-centered plans address all participants' assessed needs, assessments are updated and revised accordingly, and services are delivered in accordance with the service plan.
- In Arizona, MCOs are required to provide an annual case management plan which outlines how all case management and administrative standards will be implemented and monitored by the MCO.
- In Massachusetts, the MCO (called the Senior Care Organization [SCO]) is required to monitor care coordination agencies to ensure that their performance and qualification requirements are met.

d. Information Technology Requirements in Support of Quality Monitoring and Reporting. All 17 states include language in their contracts related to information technology requirements. However, several contracts are generic with regard to information technology and the functions it must support. Examples of contracts that call out information technology support for quality activities include:

- Delaware, Florida, Michigan, New Mexico and Wisconsin require MCOs to maintain a health information system that provides information on quality areas including service utilization, grievances and appeals.
- North Carolina MCOs are required to maintain an information system that collects, analyzes, integrates, and reports data for recipients with

behavioral health, developmental disability, and substance abuse treatment needs.
- Texas requires MCOs to maintain an information system that supports all quality functions of the MCOs as well as their subcontractors.

e. Critical Incidents Reporting/Investigation Requirements. Fourteen states include language in their contracts that require MCOs to have critical incident reporting processes and many of these states enumerate the actual critical incidents that they must incorporate into their systems. In addition, some states require the MCO to contact the state in the event of certain critical incidents (e.g., deaths, abuse, neglect, exploitation).

- Wisconsin requires MCOs to have designated staff to conduct critical incident investigations and to determine whether any changes in the MCO or provider policies or practices might prevent occurrence of similar incidents in the future.
- Michigan requires that the Pre-paid Inpatient Health Plans (PIHPs) (MCO entities in Michigan) notify the state immediately of any deaths.
- Florida requires that MCOs contact the state within 48 hours when there is any incident that may jeopardize the health, safety and welfare of an enrollee or impair continued service delivery.
- Massachusetts requires SCOs to inform the state the next business day when there is an incident related to abuse, neglect or exploitation.
- Hawaii does not require the MCO to have a critical incident system but does require the MCO to report instances of abuse, neglect, and exploitation to the appropriate state agency.

f. Required Mechanisms for Monitoring Receipt of LTSS Services. Ten states include contract language related to mechanisms for monitoring receipt of community LTSS services and associated reporting requirements. There is a fair amount of variability in these monitoring mechanisms from the real-time Electronic Visit Verification (EVV) System in Tennessee (where the MCO is alerted to late receipt of services in a member's service plan) to retrospective verification of service receipt for which a provider has billed.
- Kansas and Tennessee MCOs are required to use an EVV System to monitor the receipt and utilization of LTSS services. The EVV System logs the arrival and departure of a provider staff person, verifies the identity of the individual provider staff person, and provides immediate notification to care coordinators if a provider does not arrive as scheduled.
- The MCOs in Pennsylvania and Wisconsin must have a mechanism to detect both under utilization and over utilization of services.
- MCOs in Michigan and Delaware must verify that services reimbursed by Medicaid were actually furnished to enrollees by a provider (although this does not necessarily guarantee that the services/supports in the member's service plan were delivered).

g. Required Mechanisms for Handling Complaints, Grievances, Appeals, and Associated Reporting. Sixteen states include language in their contracts related to MCO mechanisms for handling complaints, grievances, and appeals. This is not surprising given that grievances and appeals are a fundamental Medicaid requirement and spelled out in detail in the federal Medicaid managed care regulations.[5] What is interesting is the variability in how this requirement is delegated to the MCOs.

- Delaware MCOs are required to maintain records of grievances and appeals and must review and analyze the information as part of the state quality strategy and take any corrective action as a result of this analysis.
- In Kansas, MCOs must provide a system to track and document all grievances and must develop a database extract file that can be imported into the state fiscal agent's grievance database.
- Massachusetts SCOs must report the number and types of complaints filed by enrollees and must cooperate with the state to implement improvements based on the findings of these reports.
- The MCOs in New Mexico must designate a member grievance coordinator with the authority to administer policies and procedures for resolution of a grievance or appeal and review patterns and trends to initiate corrective actions as-needed.
- In Tennessee, each MCO is required to devote a portion of its regularly scheduled quality committee meeting to review member complaints and appeals.

## 2. Required LTSS Performance Measures

Thirteen states include language related to LTSS performance measures in their MCO contracts. Some measures focus on the processes for response time to respond to referrals, timeliness of receipt of covered services, timeliness of care plan implementation, process for handling critical incidents, and process for coordination of services. Examples of these process measures include:

- Percent of members offered an initial appointment within ten days of initial contact.
- Percent of appeals resolved as expeditiously as the enrollees' health condition requires.
- Percent of beneficiaries receiving a pre-admissions screening for psychiatric inpatient care for whom the disposition was completed within three hours.

[5] CFR 438:228; CFR 438:700-424.

- Percent of new beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service.
- Percent of complaints received and resolved.
- Percent of grievances received and resolved.
- Percent of discharges from a psychiatric inpatient unit seen for follow-up care within seven days.
- Percent of re-admissions at 30 days, 90 days and one year from last discharge from state mental health hospital, psychiatric inpatient program, or Psychiatric Residential Treatment Facility.
- Percent of new enrollees who have met with their service coordinator.
- Percent of enrollees diagnosed with dementia who are receiving geriatric support services.
- Percent increase in enrollees that receive participant-directed personal care.
- Percent of depression screens conducted on a quarterly basis.

Several contracts also specify outcomes related to community retention rate, rate of preventable hospital admissions, rates of nursing facility (NF) and chronic hospital admission. Examples of outcome performance measures in the reviewed contracts include:

- Percent of enrollees reporting their physical health as good.
- Percent of enrollees reporting they are connected to the people who support them the most.
- Percent of enrollees reporting they are doing what they want for their work.
- Percent of enrollees who report having a place to live that is comfortable for them.
- Percent mentally ill/developmentally disabled beneficiaries who are in competitive employment.
- Percent of mentally ill/developmentally disabled beneficiaries readmitted to an inpatient psychiatric unit within 30 days of discharge.
- Percent of mentally ill/developmentally disabled beneficiaries who live in a private residence alone, or with spouse or non-relative.
- Reduction in law enforcement involvement.
- Reduction in psychiatric inpatient and emergency room hospitalizations.
- Reduction in law enforcement involvement.
- Reduction in mental health crisis interventions.
- Reduction in falls.
- Increase in percentages of participants with jobs or volunteer opportunities.

One cannot assume that because a contract does not enumerate performance measures that the MCO has no responsibility for reporting measures and using

them as barometers for performance and improvement. Tennessee's contract is a good example. While no performance measures are specifically articulated in that contract, the quality reports that the MCO is required to produce clearly include information that measure the MCO's performance in multiple domains.

### 3. Required Performance Improvement Projects (PIPs)

All 17 states require that MCOs carry out 2-3 PIPs that focus on clinical and non-clinical areas. This is not surprising given that CFR 438 requires "*an ongoing program of PIPs that focus on clinical and non-clinical areas*."[6] Indeed much of the PIP language in many of these contracts is taken verbatim from CFR 438 and the reader will observe this in the contract summaries in the Appendices.

What we were most interested in learning from the scan was whether contracts specified PIPs related specifically to the LTSS nature of the program (i.e., PIPs focusing on clinical conditions/outcomes or non-clinical services/providers/ outcomes for the LTSS population(s) served). The language in the contracts is often vague enough that it is difficult to tell whether there are any LTSS-related PIP requirements. Out of the seventeen contracts, only two clearly articulated LTSS-specific PIP requirements.

- In Washington, MCOs must collaborate with peers to conduct one non-clinical statewide PIP focused on enrollees with special health care needs or who are at risk for re-institutionalization, re-hospitalization, or substance use.
- Tennessee requires MCOs to perform at least one PIP relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.

### 4. Required Involvement with the External Quality Review Organization (EQRO)

All 17 states include language regarding the role of an EQRO which includes validation of performance measure data and PIP--also expected given the CFR 438 requirement for an external quality review.[7] Again, the reader will observe in the Appendices contract summaries, states have dropped into the documents verbatim language from CFR 438. Most include language that requires MCOs to cooperate with the EQRO.

### 5. Care Coordination Requirements

a. Assessment Requirements. Fourteen states require that MCOs use either a state assessment form or a form approved by the state to determine member needs and/or level of care eligibility for the LTSS program.

[6] CFR 438.236.

[7] CFR 438.438.310-370.

b. Care Coordinator/Member Ratio Requirements. Only six states include language in their MCO contracts that establish caseload ratios.

- Caseload maximums in Arizona are calculated based on a weighting scheme that takes into account the care coordinators' mix of members (HCBS, NF, Assisted Living, etc.).
- Tennessee MCOs are not held to a specified caseload ratio but are required to provide monthly reports to the state on staffing ratios.
- MCOs in Delaware must maintain varying case manager staffing ratios for members in NFs, those receiving HCBS, and Money-Follows-the-Person participants.
- Illinois' ratios are based on level of case management need (intensive versus supportive) of enrollees.
- In Hawaii, service coordinator caseloads cannot exceed 1,880 hours annually. Hawaii also has limits on the number of members a service coordinator is allowed to serve.
- Minnesota requires MCOs to submit policies and criteria for caseload ratios to the state for review.

c. Frequency and Nature of Member Monitoring Requirements. One of the major functions of most care coordination is to monitor the service delivery to and well-being of members. Ten state contracts specify expectations about how these functions will be carried out.

- Delaware MCOs must conduct on-site member reviews at least every 180 days for members in an institutional setting and every 90 days for a member receiving HCBS.
- Service coordinators in New Mexico are required to meet face-to-face with members at least once quarterly and by telephone contact at least once monthly.
- In Massachusetts, SCOs must perform needs assessments at least every six months or whenever an enrollee experiences a major change. A quarterly assessment is required for enrollees who require complex care.
- In Pennsylvania, the MCO must review the plan at least every three months and after each episode that triggers implementation of crisis intervention or the use of a restraint.
- In Wisconsin MCOS are required to conduct face-to-face visits with a member every three months. After the first six months of enrollment, if the MCO staff has established a relationship with the member, the minimum standard can be waived but a member must receive at least one face-to-face visit each year.

d. LTSS-Acute Care Coordination Requirements. Regardless of whether a program offers both managed medical care and LTSS or just MLTSS,

coordination of medical and LTSS is in the member's best interest. Indeed coordination is one of the hallmarks of managed care. It is interesting to observe that nearly all the contracts (16) include clauses requiring such coordination.

- Illinois requires MCOs to establish a community-based Integrated Care Team that consists of a care coordinator, community liaison, and service provider representative. The team is supported by the MCO's medical staff. If an enrollee is receiving medical care or treatment in an acute care hospital, the MCO is required to assume responsibility for the management of such care.
- Florida MCOs must ensure that all subcontractors delivering services covered by the contract agree to cooperate with the goal of an integrated and coordinated service delivery system for the enrollee.
- In Hawaii, MCOs are required to have a patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings.
- Minnesota requires MCOs to provide case management services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post-acute and rehabilitation services by providing each enrollee with a primary contact person who will assist the enrollee in simplifying access to services and information. The contract also requires MCOs to develop and implement written policies and procedures that ensure that health and social service delivery is coordinated across providers and service systems.
- Washington requires MCOs to have written operational agreements with the state, community physical and behavioral health hospitals, long-term care facilities, and drug and alcohol treatment programs for the purpose of facilitating transitions of care for enrollees.

e. Risk Assessment and Mitigation Requirements. Nine states include requirements related to risk assessment and mitigation in their MCO contracts but they vary in the type of risk focused upon and whether mitigation requirements are specified.

- Illinois requires MCOs to indentify categories of risk for enrollees (no risk, moderate risk or high risk) using a health risk questionnaire.
- In Massachusetts, SCOs must have protocols to monitor risk assessment mechanisms to identify enrollees at risk of institutionalization or hospitalization for pneumonia, dehydration, injuries from falls, skin breakdown, loss of informal caregiver, and non-compliance with treatment programs.
- Aiming at risk mitigation, MCOs in Tennessee must conduct a risk assessment using a state-specified tool and protocol and develop, as applicable, a risk agreement to be signed by the applicant or his/her representative. The agreement must include identified risks to the

applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk.
- In Wisconsin MCOs are required to have a mechanism to monitor, evaluate and improve their performance in the area of safety and risk issues.

## 6. Ombudsman--Like Functions Requirements

Eight states address either the availability of an Ombudsman program or require the MCO to fulfill some ombudsman-like functions (e.g., member advocacy) in their contracts.

- Wisconsin, Tennessee, Massachusetts and Hawaii include language that references an external or state Ombudsman program/service to which the MCO can refer members.
- Minnesota has established a state Ombudsman office for managed care enrollees and MCOs are required to inform the enrollee of assistance available through this office.
- Texas and Delaware require MCOs to employ member advocates to work with members and providers to facilitate the provision of benefits.
- Tennessee requires MCOs to have a consumer advocate for members responsible for internal representation of members' interests and member, family, and provider education.
- In Texas, MCOs must provide advocates to assist members in writing or filing an appeal and monitoring the appeal through the MCO's appeal process until the issue is resolved.

## 7. Financial Incentives for Performance

Nine states include financial incentives for performance in their contracts with MCOs.

- Illinois, Kansas, Minnesota and Texas have established an incentive pool from which MCOs may earn payments based on performance with respect to specific quality metrics. To fund the pool, states withhold a portion of the MCOs capitation rate. In addition, Texas has created a Quality Challenge Award to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction as determined by the state.
- New Mexico's contract indicates that the state may provide incentives to MCOs that receive exceptional grading for ongoing performance for quality assurance standards, performance indicators, etc.
- Tennessee and Hawaii have incentives for meeting established performance and quality goals using Health Effectiveness Data and Information Set measures and other benchmarks.

- Michigan has established monetary awards for PIHPs showing relative improvement over the previous fiscal year without receiving a non-compliance score in the site review.

## 8. Experience of Care/Satisfaction Feedback Requirements

Nine states include language in their contracts related to experience of care/satisfaction surveys or focus groups. That said, language in the contracts was not always specific enough to determine if the required feedback mechanism included a focus on LTSS as most of the examples below exhibit. Some states may assume this responsibility or employ an independent vendor for this purpose rather than delegate this activity to MCOs. Thus the reader should not assume that if such a requirement is not included in the MCOs contract that the state does not have a LTSS feedback mechanism in place.

- Delaware MCOs must survey their members on an annual basis and must agree to collect and assist the state in gathering annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members.
- In Florida, the MCOs are required to conduct an enrollee satisfaction survey for members having received long-term care services.
- Michigan PIHPs are required to conduct periodic surveys and focus groups to assess member experiences with its services addressing issues of the quality, availability, and accessibility of care.
- SCOs in Massachusetts must administer an annual survey to all enrollees and report the results to the state. SCOs must conduct one survey or focus group with each of the following groups: non-English speaking enrollees, persons with physical disabilities, enrollees from a minority ethnic group served by the SCO, and family members and significant caregivers of enrollees.
- In New Mexico, MCOs must conduct at least one annual survey of member satisfaction with input from the Consumer Advisory Board and the state to assess member satisfaction with quality, availability, and accessibility of services.
- North Carolina MCOs are required to conduct a patient satisfaction survey annually using a survey instrument approved by the state and administered by an outside vendor.
- In Wisconsin, MCOs are required to survey members or a representative sample to identify member level of satisfaction with the MCO's services using a set of standardized questions provided by the state.

## 9. Quality Improvement Reports

Sixteen states include language in their MCO contacts related to LTSS Quality Reports. Some states require quarterly reports and others require annual reports. Some examples of the information/data that MCOs must report to the state include:

- Critical incidents such as hospitalizations, falls resulting in hospitalizations, behavior resulting in injury to self or others, medical errors resulting in hospitalizations, deaths, etc.
- Results of member satisfaction/experience of care surveys.
- Performance data for specific performance measures.
- Complaint, grievance and appeal reports.
- MCO program goals, objectives, work plans, timetables for implementation, accomplishments, and improvements.
- Reports of preventable hospitalizations and admissions/discharges from nursing homes facilities.
- Number of members engaged in meaningful employment.
- Late and missed provider visit reports.
- Provider recognition and training reports.

| EXHIBIT 1. MLTSS MCO Quality Contract Requirements | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Requirements** | **AZ** | **DE** | **FL** | **HI** | **IL** | **KS** | **MA** | **MI** | **MN** | **NM** | **NY** | **NC** | **PA** | **TN** | **TX** | **WA** | **WI** |
| Staffing for Quality Oversight | * | * | * | * | * | * | * | * | | * | * | * | * | * | * | * | * |
| Provider Monitoring | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| Care Coordinator Monitoring | * | | * | * | * | * | * | | * | | | * | | * | * | | * |
| Information Technology | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| Critical Incident Processes | * | * | * | * | * | * | * | * | | * | | * | * | * | | * | * |
| Monitoring Receipt of LTSS Services | | * | * | | | * | * | * | | | * | | * | * | | * | * |
| Complaints, Grievances, Appeals | * | * | * | * | * | * | * | | * | * | * | * | * | * | * | * | * |
| LTSS Performance Measures | * | | | * | * | * | * | * | | * | * | * | * | | * | * | * |
| EQRO | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| Assessment Tools | * | | * | * | * | * | * | | * | | * | * | * | * | * | * | * |
| Care Coordinator-Member Ratio | * | * | | * | * | | | | * | | | | | * | | | |
| Frequency of Member Monitoring | * | * | * | | | * | * | | * | * | | | * | * | | | * |
| LTSS-Acute Care Coordination | * | * | * | * | * | * | * | | * | * | * | * | * | * | * | * | * |
| Risk Assessment and Mitigation | | | | * | * | * | * | | * | * | | | * | * | | | * |
| Ombudsman | * | * | | * | | | * | | * | | | | | * | * | | * |
| Quality-Related Financial Incentives | | * | | * | * | * | | * | * | * | | | | * | * | | |
| Experience of Care | | * | * | | | | * | * | * | * | | * | * | | | | * |
| Quality Improvement Reports | * | * | * | * | * | * | * | | * | * | * | * | * | * | * | * | * |

# APPENDICES

## State MLTSS MCO Quality Contract Requirements Summaries

**APPENDIX A**. Arizona Long-Term Care System

**APPENDIX B**. Delaware Diamond State Health Plan-Plus

**APPENDIX C**. Florida Long-Term Care Community Division Pilot Project

**APPENDIX D**. Hawaii QUEST Expanded Access

**APPENDIX E**. Illinois Integrated Care Program

**APPENDIX F**. Kansas KanCare

**APPENDIX G**. Massachusetts Senior Care Options

**APPENDIX H**. Michigan Medicaid Managed Specialty Supports and Services

**APPENDIX I**. Minnesota Senior Care Plus and Minnesota Senior Health Options

**APPENDIX J**. New Mexico Coordination of Long-Term Services

**APPENDIX K**. New York Medicaid Advantage Plus

**APPENDIX L**. North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan Waiver

**APPENDIX M**. Pennsylvania Adult Community Autism Program

**APPENDIX N**. Tennessee TennCare CHOICES

**APPENDIX O**. Texas STAR+PLUS

**APPENDIX P**. Washington Medicaid Integration Partnership

**APPENDIX Q**. Wisconsin Family Care

# APPENDIX A. ARIZONA LONG-TERM CARE SYSTEM

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Arizona Health Care Cost Containment System (AHCCCS) |
| Program | Arizona Long-Term Care System (ALTCS) |
| Inception | 1988-1989 |
| Year LTSS Added | N/A |
| Medicaid Authority | 1115 Research and Demonstration Waiver |
| # Enrolled | 52,251 (May 2012) |
| Group Enrolled | Elderly, physically disabled, and DD. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO is required to have the following key staff positions for quality oversight/reporting:<br>• The Medical Director/CMO is a state licensed physician who:<br>- Is actively involved in all major clinical and QM components of the contract.<br>- Oversees the QM/PI program monitoring and evaluation activities.<br>- Serves as chair to quality oversight committees.<br>• The QM Coordinator is a state-licensed RN, physician or physician's assistant or is a CPHQ by the NAHQ and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers. The QM Coordinator must have experience in QM and QI. The primary functions of the QM Coordinator position are to:<br>- Ensure individual and systemic quality of care.<br>- Integrate quality throughout the organization.<br>- Implement process improvement.<br>- Resolve, track and trend quality of care grievances.<br>- Ensure a credentialed provider network.<br>• The Performance/QI Coordinator has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in data and outcomes measurement. The primary functions of the Performance/QI Coordinator are to:<br>- Focus organizational efforts on improving clinical quality performance measures.<br>- Develop and implement PIPs.<br>- Utilize data to develop intervention strategies to improve outcomes.<br>- Report QI/performance outcome.<br><br>The MCO must ensure that the QM/QI Unit within the organizational structure is separate and distinct from any other units or departments (e.g., Medical Management or Case Management units). |

| Element | Description/Notes |
|---|---|
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to demonstrate that providers are credentialed and reviewed through the MCO's Credentialing Committee chaired by the MCO's Medical Director. The provider monitoring shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the MCO. The MCO must submit a Credentialing Quarterly Report. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>MCOs shall provide an annual Case Management Plan which outlines how all case management and administrative standards will be implemented and monitored by the MCO. The administrative standards shall include but not be limited to a description of the MCO's systematic method of monitoring its case management program. The plan shall also include an evaluation of the MCO's Case Management Plan from the prior year to include lessons learned and strategies for improvement.<br><br>The MCO shall implement a systematic method of monitoring its case management program to include but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations (inter-rater reliability). The MCO shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the MCO has taken to resolve identified issues. The MCO shall ensure adequate staffing to meet case management requirements. The MCO's case management plan shall also describe their methodology for assigning and monitoring case management caseloads. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO must have a health information system that integrates member demographic data, case management information, provider information, service provision, claims submission and reimbursement and be capable of collecting, storing and producing information for the purposes of financial, medical and operational management. The MCO shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims and must be adaptable to updates to meet changing policies as-needed.<br><br>The MCO must include nationally recognized methodologies to correctly pay claims, able to assess and/or apply data related edits, and produce remittance advice related to payments and/or denials to providers. To record and track placement history and cost effectiveness studies, the MCO must have a CATS. MCOs are not required to enter service authorizations into the CATS. However, the MCO is expected to maintain a uniform tracking system in each member chart documenting the beginning and end date of services inclusive of renewal of services and the number of units authorized for services. |

| Element | Description/Notes |
|---|---|
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The MCO is required to track and trend member and provider issues which include investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:<br>• Acknowledgement letter to the originator of the concern.<br>• Documentation of all steps utilized during the investigation and resolution process.<br>• Follow-up with the member to assist in ensuring immediate health care needs are met.<br>• Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and an MCO contact name/telephone number to call for assistance or to express any unresolved concerns.<br>• Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern.<br>• Analysis of the effectiveness of the interventions taken. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>MCOs are required to have a written grievance system process for subcontractors, enrollees and non-contracted providers which define their rights regarding disputed matters with the MCO. The MCO's grievance system for enrollees includes a grievance process (procedures for addressing enrollee grievances), an appeals process, and access to the state's fair hearing process. The MCO shall also ensure that it timely provides written information to both enrollees and providers which clearly explain the grievance system requirements. The MCO will provide reports on the grievance system to the state. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | State has 32 Quality Standards for the contractors. LTSS-related quality measures include items such as structure and process for handling CIs both individual and systems-level; initiation of services; and, coordination of services with PCP. |

| Element | Description/Notes |
|---|---|
| 3. PIP Requirements | MCOs are required to have an ongoing PIPs that focus on clinical and non-clinical areas that involve:<br>• Measurement of performance using objective quality indicators.<br>• Implementation of system interventions to achieve improvement in quality.<br>• Evaluation of the effectiveness of the interventions.<br>• Planning and initiation of activities for increasing or sustaining improvement.<br><br>PIPs are mandated but MCOs may select additional projects based on opportunities for improvement identified by internal data and information. 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. MCO must submit PIP baseline, re-measurement and final reports to the state. |
| 4. EQRO Requirements | The state contracts directly with the EQRO and submits all data to the EQRO. There is no direct coordination between the EQRO and MCOs. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The MCO case manager must complete a UAT based on information from the strengths/needs assessment to determine the member's current LOC. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>Each case manager's caseload may not exceed a weighted value of 96 base on the following formula:<br>• Number of HCBS members x 2.0.<br>• Number of ALF members x 1.6.<br>• Number of ACO members x 1.0.<br>• Plus number of NF members x 0.8.<br><br>MCOs may assign a weighted value lower than those outlined. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>The MCO is required to initiate a SP for each member at the time of enrollment. The SP shall identify the immediate health care needs of each newly enrolled member with an action plan. The comprehensive SP must be developed within 60 calendar days from date of the initial medical service and contain all the required elements. The MCO case manager modifies and updates the SP when there is a change in the member's condition or recommended services. This will occur periodically as determined by the member, family, or provider. |

| Element | Description/Notes |
|---|---|
| | **d. LTSS/acute care coordination requirements.**<br><br>MCOs must identify and facilitate coordination of care for all members during changes or transitions between MCOs, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include members designated as having "special health care needs".<br><br>If a member is referred to and approved for long-term care, the MCO must coordinate the transition with the assigned long-term care facility provider to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |
| 6. Ombudsman (Function) Requirements | The MCO is required to have a Dispute and Appeal Manager who will manage and adjudicate member and provider disputes arising including member grievances, appeals and requests for hearing and provider claim disputes. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | The MCO is required to submit reports on member services/case management and credentialing.<br><br>The MCO's QM program shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time in the areas of clinical care and non-clinical care expected to have a favorable effect on health outcomes and member satisfaction. The MCO must:<br>• Measure and report to the state its performance using standard measures required by the state by CMS.<br>• Submit to the state data specified by the state that enables the state to measure the MCO's performance. |

ACO = accountable care organization
AHCCCS = Arizona Health Care Cost Containment System
ALF = assisted living facility
ALTCS = Arizona Long-Term Care System
CATS = Client Assessment and Tracking System

CHCQM = Certified in Health Care Quality and Management
CI = critical incident
CMO = Chief Medical Officer
CMS = Centers for Medicare and Medicaid Services
CPHQ = Certified Professional in Healthcare Quality

DD = developmental disability

EQRO = external quality review organization
HCBS = home and community-based services
HIPAA = Health Insurance Portability and Accountability Act
IT = information technology

LOC = level of care
LTSS = long-term services and supports
MCO = managed care organization
NAHQ = National Association of Health Care Quality
NF = nursing facility

PCP = primary care provider/physician
PIP = performance improvement project
QI = quality improvement
QM = quality management
RN = registered nurse

SP = service plan
UAT = Uniform Assessment Tool

# APPENDIX B. DELAWARE DIAMOND STATE HEALTH PLAN-PLUS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance |
| Program | Diamond State Health Plan-Plus (DSHP-Plus) |
| Inception | April 1, 2012 |
| Year LTSS Added | 2012 (LTSS added to DSHP) |
| Medicaid Authority | 1115 Demonstration |
| # Enrolled | 4,800 |
| Group Enrolled | Elderly, persons with PD, persons with HIV/AIDS, children, and Medicare-Medicaid enrollees. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO must employ QM staff with experience working with the long-term care population. The MCO must designate a QM coordinator who is either the MCO's medical director or a person who directly reports to the medical director. This individual is responsible for the:<br>• Development and implementation of the quality strategy.<br>• Interface and support of the EQRO.<br>• Development of the MCO's annual written quality strategy (including objectives, scope, specific activities, and methodologies for continuous tracking, provide review and focus on health outcomes).<br>• Monitoring of the quality of care that MCO members receive and the review of all potential quality of care problems.<br>• Oversight of the development and implementation of continuous assessment and improvement of the quality of care provided to members.<br>• Clinical or health service areas to be monitored.<br>• Specification of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by the state and MCO.<br>• HEDIS standard.<br>• MCO's QM committee.<br><br>The MCO also must have a QM Committee that assists the coordinator in carrying out the quality strategy. The MCO must have policies and procedures that clearly define the roles, functions, and responsibilities of the QM committee and medical director. The Committee will have oversight responsibility and input on all QM activities. |

| Element | Description/Notes |
|---|---|
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs must have written policies and procedures which include selection and retention of providers, credentialing and re-credentialing, and non-discrimination requirements. The MCO must have written policies and procedures for determining and assuring that all providers with which it contracts are licensed by the state or meet business participation criteria and are qualified to perform their services.<br><br>The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with National Medical Practice and Credentialing Standards. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, and grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The MCO must collect data on member and provider characteristics as specified by the state, and on services furnished to members through an encounter data system or other methods as specified by the state. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs are required to develop and implement a CI reporting system for incidents that occur with its members related to the provision of covered services. CIs shall include:<br>• Unexpected death of a member.<br>• Suspected physical, mental or sexual abuse and/or neglect of a member.<br>• Theft or financial exploitation of a member.<br>• Severe injury sustained by a member.<br>• Medication error involving a member.<br>• Inappropriate/unprofessional conduct by a provider involving a member.<br><br>MCOs regularly identify, track, review and report (within 24 hours) CIs to the state. MCOs review and analyze CIs to identify and address potential and actual quality of care and/or health and safety issues. MCOs require providers involved in a CI to conduct an investigation and submit a report within the timeframe specified by the MCO. MCOs shall review provider reports and follow-up as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes. MCOs submit monthly reports to the state regarding all CIs. |

| Element | Description/Notes |
|---|---|
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>MCOs must have processes to identify utilization problems and undertake corrective action. MCOs must have policies and procedures to verify that services were provided and report findings to state.<br><br>The MCO must employ sampling methods and operational procedures to verify with its members whether services billed to the MCO by providers were actually received. The MCO must submit a report to the state detailing the results of its sampling. The MCO must collect all health care related criminal conviction information from the MCO's network providers and immediately report this information to the state. For each case of suspected fraud and abuse, following the MCO's investigation, the MCO must report to the state the following: provider's name source of the complaint, type of provider, nature of the complaint, and approximate range of dollars involved. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>MCOs are required to establish internal grievance procedures so members (or providers acting on their behalf) may challenge the denial of coverage. MCOs must have a system in place for members that includes a grievance process, an appeal process, and access to the state's Fair Hearing system. The MCO must ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and have the appropriate clinical expertise as determined by the state.<br><br>MCOs must establish and maintain an expedited review process for appeals when the MCO determines that taking the time for standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must address each grievance and resolve each appeal, and provide notice as expeditiously as the member's health condition requires within state established timeframes.<br><br>MCOs are required to maintain records of grievances and appeals and must review the information as part of the state quality strategy. MCOs are required to follow all state-specified grievance and appeal data requirements. MCOs must provide the state with quarterly reports documenting the number and types of grievances and appeals registered by members and providers and the status or disposition of grievances/appeals including:<br>• Grievance rate by medical nature of grievance.<br>• Number of provider complaints by nature of complaint and resolution.<br>• Number of families or caregivers of enrolled children with special health care needs from whom MCO has received a written complaint regarding accessibility or quality of services specified in the child's care plan.<br>• Number of appeals by medical nature of appeal and outcome.<br>• Analysis that identifies trends and/or patterns for administrative use and review including any corrective action taken as a result of the analysis. |
| | **h. Other.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| 2. LTSS Performance Measures Requirements | None specified. |
| 3. PIP Requirements | PIP requirements are general in nature with no specifications on MLTSS. |
| 4. EQRO Requirements | The state contracts with independent, external evaluators to examine the quality of care provided by MCOs. The state also designates an additional outside review agency to conduct an evaluation of the program and its progress toward achieving program goals.<br><br>MCOs are required to cooperate with any external quality or independent assessment of its performance which has been authorized by or performed by the state. Independent assessments shall include reviews of:<br>• Access to care, quality of care, cost effectiveness, and effect of case management.<br>• The MCO's QA procedures, implementation of the procedures, and the quality of care provided.<br>• Consumer satisfaction surveys.<br><br>MCOs must identify, collect and provide any data or medical records to be reviewed by the independent assessors as requested. The monitoring and evaluation of MCOs will be conducted through periodic review of:<br>• Data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the enrolled populations.<br>• Evaluation of encounters.<br>• On-site visits and inspection of facilities.<br>• Staff and member interviews.<br>• Appointment scheduling logs, ER logs, denial of services, and other areas that will indicate quality of care delivered to members.<br>• Medical records review of all quality strategy procedures, reports, and recommendation and corrective actions.<br>• Staff and provider qualifications.<br>• Grievance procedures and resolutions.<br>• Requests for transfer between PCPs within contractor's network. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>None specified. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>The MCO must maintain case manager staffing ratios of:<br>• 1:120 for NF members.<br>• 1:60 for members receiving HCBS (own home or assisted living).<br>• 1:30 for members receiving services under the MFP program. |

| Element | Description/Notes |
|---|---|
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>Case managers are responsible for ongoing monitoring of the services and placement of each member assigned to their caseload in order to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers.<br><br>Member placement and services must be reviewed on-site with the member present within the following timeframes:<br>• At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in uncertified institutional settings).<br>• At least every 90 days for a member receiving HCBS.<br>• At least every 90 days for a member residing in an alternative residential setting.<br>• At least every 90 days for a community-based member receiving acute care services only.<br><br>Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year. MCOs may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion but may not determine members to need less frequent visits. |
| | **d. LTSS/acute care coordination requirements.**<br><br>Case managers are expected to use a person-centered approach regarding the member assessment and needs taking into account covered services and other needed community resources as applicable. Case managers are expected to provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on members and assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education and employment. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| 6. Ombudsman (Function) Requirements | MCOs are required to employ at least 1 member advocate to work with members and providers to facilitate the provision of benefits. The advocate is responsible for making recommendations to MCO management regarding any changes needed to improve the care provided or the manner in which the care is delivered. The person must have the authority needed to carry out these tasks. The advocate will:<br>• Investigate and resolve access and cultural sensitivity issues identified by the MCO, state, providers, advocate organizations, and members.<br>• Monitor MCO formal and informal grievances with the grievance personnel to look at trends or major areas of concern.<br>• Coordinate with schools, community agencies and state agencies providing services to members.<br>• Recommend policy and procedural changes to MCO management including those needed to ensure/improve member access to care and quality of care.<br>• Function as a primary contact for member advocacy groups and work with these groups to identify and correct member access barriers.<br>• Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of members.<br>• Analyze systems functions through meetings with staff.<br>• Provide training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCOs interact.<br>• Provide input to MCOs on how provider changes affect access and quality/ continuity of care, and develop plans to minimize potential problems.<br>• Review all informational material to be distributed to members.<br>• Assist members and authorized representatives obtain medical records. |
| 7. Quality-Related Financial Incentives | The state, in conjunction with the MCO, will develop a system of incentives for reaching health care outcome objectives in certain key areas to be defined by the state and MCO. These outcome objectives include childhood immunizations, prenatal care, birth outcomes, pediatric asthma, and behavioral health care. MCOs are required to submit on a periodic basis objective numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for enrolled populations. The state, the EQRO, and the MCO will also cooperate in the collection of data in order to provide accurate reports that can be used by the state to create new millennial outcome measures for the health and wellness of all residents of the state. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | The contract specifies that MCOs must survey their members on at least an annual basis to determine satisfaction with MCO services but does not indicate whether the survey must include satisfaction with LTSS services. |
| 9. LTSS Quality Review | MCOs must provide the state with utilization, QA, financial and member satisfaction/complaint data on a regular basis and provide reports on long-term care, behavioral health and children with special health care needs, including information on expenditures, enrollment, access, quality of care, modality of care, and length of stay. |

AIDS = Acquired Immunodeficiency Syndrome
CI = critical incident
DSHP-Plus = Diamond State Health Plan Plus
EQRO = external quality review organization
ER = emergency room

HCBS = home and community-based services
HEDIS = Health Effectiveness Data and Information Set
HIV = Human Immunodeficiency Virus
IT = information technology
LTSS = long-term services and supports

MCO = managed care organization
MFP = Money-Follows-the-Person
MLTSS = managed long-term services and supports
NF = nursing facility
PCP = primary care provider/physician

PD = physical disability
PIP = performance improvement project
QA = quality assurance
QM = quality management

# APPENDIX C. FLORIDA LONG-TERM CARE COMMUNITY DIVERSION PILOT PROJECT

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Florida Department of Elder Affairs<br>Contract covering 2012 through August 2013 |
| Program | Long-Term Care Community Diversion Pilot Project |
| Inception | 1998 |
| Year LTSS Added | 1998 |
| Medicaid Authority | 1915(a)/(c) |
| # Enrolled | 19,283 (as of April 2012) |
| Group Enrolled | Frail elders age 65 and older who are eligible for nursing home care. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCOs shall have a designated individual with a degree in Health Information Management or equivalent program and with a CPHQ designation responsible for the MCO's QA program. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to monitor the subcontractor's performance on an ongoing basis and conduct formal reviews according to a periodic schedule established by the state consistent with industry standards or state MCO laws and regulations. The MCO shall identify deficiencies or areas for improvement. The MCO and the subcontractor must take corrective action where deficiencies or areas for improvement are found.<br><br>The MCO is required to have a credentialing and re-credentialing process with written policies and procedures, and a description of its policies and procedures for selection and retention of providers following the state's policy for credentialing and re-credentialing. |

| Element | Description/Notes |
|---|---|
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>For enrollees in an assisted living or NF, the MCO is required to ensure coordination with the medical, nursing, or administrative staff designated by the facility to ensure that the enrollees have timely and appropriate access to the MCO's providers and to coordinate care between these providers and the facility's providers.<br><br>For those enrolled in the MCO's Medicare Advantage Plan, the MCO must have protocols to ensure that all acute care services and long-term care services are coordinated. The enrollee's case manager must coordinate with the PCP, as well as the enrollee or other appropriate person, in the development of acute and long-term care plans. The MCO must ensure that all subcontractors delivering services covered by the contract agree to cooperate with the goal of an integrated and coordinated service delivery system for the enrollee.<br><br>When enrollees elect to remain in the Medicare FFS system, the MCO must establish protocols to ensure that services are coordinated to the maximum extent feasible for these enrollees. The case manager must actively pursue coordination with the enrollee's PCP and other care providers. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs shall maintain a health information system that collects, analyzes, integrates, and reports data so the federal requirements are met. The system must provide information on areas including but not limited to utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs are required to implement a systematic process for incident reporting and shall require all subcontractors to comply with this process. The MCO is required to notify the state within 48 hours of an occurrence of an incident that may jeopardize the health, safety and welfare of an enrollee or impair continued service delivery. Additionally, the contractor shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the appropriate authorities. The MCO shall maintain an incident log that shall be available for inspection by the state and shall submit an incident report to the state for every member for whom an incident has occurred. Reportable conditions include, but are not limited to:<br>• Closure of subcontracted facilities due to license violations.<br>• Contractor or subcontractor financial concerns/difficulties.<br>• Loss or destruction of enrollee records.<br>• Compromise of data integrity.<br>• Fire or natural disasters.<br>• Critical issues or adverse incidents that affect the health, safety, and welfare of enrollees.<br><br>In the incident log, the MCO shall include a brief summary of the problem(s) and proposed corrective action plans and timeframes for implementation within a reasonable time after the incident is reported. |

| Element | Description/Notes |
|---|---|
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>MCOs shall contact enrollees at least once a month by telephone or face-to-face. MCOs must ensure the review of the care plan is performed through face-to-face contact with the enrollee at least every third month. The care plan review must address the adequacy and appropriateness of services and determine that services furnished are consistent with the nature and severity of the enrollee's needs. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO shall develop, implement, and ensure that its subcontractors have established grievance procedures to process and resolve client dissatisfaction with or denial of service(s), and address complaints regarding the termination, suspension or reduction of services, as required for receipt of funds. These procedures, at a minimum, will provide for notice of the grievance procedure and an opportunity for review of the subcontractor's determination(s). The MCO shall also have a description of grievance and appeals process in the Enrollee Handbook, along with the toll-free number to submit a grievance or appeal. The MCO is also responsible for maintaining a case record which shall include documentation of the discussion of the procedures for filing complaints and grievances. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | None specified. |
| 3. PIP Requirements | The focus of PIPS varies dependent upon issues identified by MCO and approved by the state. MCOs perform 2 PIPs:<br>• 1 PIP must be a statewide collaborative PIP coordinated by the EQRO.<br>• 1 PIP must address deficiencies identified by the MCO through monitoring, performance measure results, member satisfaction surveys, or other similar means.<br>• Populations selected for study under the PIP must be specific to the enrollees in the MCO. |
| 4. EQRO Requirements | MCOs are required to participate with the EQRO on all performance measure validation activities including a site visit and submission of requested documentation. The MCO may work with the EQRO on statewide collaborative PIPs. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>MCOs are responsible for long-term care planning and annual face-to-face reassessments using a state form. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. However, MCOs must have sufficient staff to conduct daily business in a manner that provides service delivery to the enrollees. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>MCOS are required to contact enrollees at least once a month either by telephone or face-to-face. MCOs are also required to review the care plan through face-to-face contact with the enrollee at least every third month. |

| Element | Description/Notes |
|---|---|
| | **d. LTSS/acute care coordination requirements.**<br><br>For those enrolled in the MCO's Medicare Advantage plan, the MCO must have protocols to ensure that all acute care services and long-term care services are coordinated. The enrollee's case manager must coordinate with the PCP, as well as the enrollee or other appropriate person, in the development of acute and long-term care plans. The MCO must ensure that all subcontractors, delivering services covered by the contract, agree to cooperate with the goal of an integrated and coordinated service delivery system for the enrollee.<br><br>When enrollees elect to remain in the Medicare FFS system, the MCO must establish protocols to ensure that services are coordinated to the maximum extent feasible for these enrollees. The case manager must actively pursue coordination with the enrollee's PCP and other care providers to the maximum extent feasible for enrollees in Medicare FFS. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | The MCO shall conduct an enrollee satisfaction survey during a specified time each year. The sampling for the survey must be a statistically significant sample of members having received long-term care services during the report period.<br><br>The MCO is required to send a copy of the survey to the state for approval. The survey shall include, but is not limited to 13 CAHPS-like questions that assess care management, satisfaction with the plan, and ALF services. The MCO shall submit the enrollee satisfaction survey results to the state. The MCO shall include an attestation statement signed by an authorized representative that addresses the validity, reliability, and whether any bias was uncovered in the survey. The attestation must describe how the validity and reliability were statistically or otherwise established and must include the measures the provider took to ensure the independence of the survey and the trust of the respondent. |
| 9. LTSS Quality Review | The MCO is required to report LTSS expenditures by service. |

ALF = assisted living facility
CAHPS = Consumer Assessment Health Care Providers and Systems
CI = critical incident
CPHQ = Certified Professional in Healthcare Quality
EQRO = external quality review organization

FFS = fee-for-service
IT = information technology
LTSS = long-term services and supports
MCO = managed care organization
NF = nursing facility

PCP = primary care provider/physician
PIP = performance improvement project
QA = quality assurance

# APPENDIX D. HAWAII QUEST EXPANDED ACCESS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Hawaii Department of Human Services, MED-QUEST Division |
| Program | QUEST Expanded Access (QExA) |
| Inception | 2009 |
| Year LTSS Added | N/A |
| Medicaid Authority | 1115 |
| # Enrolled | 44,600 (December 2011)<br>Subset using LTSS: 6,830 |
| Group Enrolled | Eligible individuals who are aged, blind, or disabled. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO is required to employ the following staff:<br>• Licensed Medical Director to oversee the quality of care furnished by the MCO and to ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct quality activities. The Medical Director shall work closely with the State Medical Director and participate in quarterly state meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by the state.<br>• QM coordinator/director responsible for all QI activities. This person shall be a licensed physician or RN.<br>• Grievance coordinator to oversee all member grievance system activities. This person shall also be responsible for the provider complaints, grievance and appeals system. The MCO may choose to delegate this function to the provider services manager.<br>• Compliance officer responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>The MCO is required to have a Credentialing Program Coordinator. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>The MCO is required to have a service coordination manager who is a RN and is responsible for all service coordination activities and oversees the hiring, training and work of all health plan service coordinators.<br><br>The MCO must submit a Service Coordinator Report which includes performance reports regarding new members who have met with their service coordinator, received a HFA, and had a care plan developed. The report also includes performance reports about members who requested a change in service coordinators. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs are required to be able to receive/transmit data files to the state via software provide by the state. MCOs are required to have and IT Director or CIO, and IT Manager, and IT staff. |

| Element | Description/Notes |
|---|---|
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs are required to report all cases of suspected abuse to protective units of the state per state and federal statutes. MCOs shall ensure that its network providers report all cases of suspected abuse to the state as well. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>MCOs shall have a grievance system that is consistent with the requirements of the state to include an inquiry process, a grievance process, and appeals process and provide information to members on accessing the state's administrative hearing system. The MCO shall require that members exhaust its internal grievance system prior to accessing the state's administrative hearing system.<br><br>All policies and procedures for the MCO's grievance system must be reviewed and approved by the state. The MCO shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. An appeal may be filed when the MCO issues a notice of action to a health plan member.<br><br>For standard resolution of an appeal, the MCO shall resolve the appeal and provide a written notice of disposition as expeditiously as the member's health condition requires but no more than 30 days from the day the MCO receives the appeal.<br><br>MCOs shall establish and maintain an expedited review process for appeals. The MCO shall resolve an expedited appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires but no more than 3 business days from the time the MCO received the appeal.<br><br>MCOs shall notify the state within 24 hours if an expedited appeal has been granted or if an expedited appeal timeframe has been requested by the member. After exhausting all grievance and appeal procedures available within the MCO and the state, the member may file a request for an external review of a MCO's final determination with the State Insurance Commissioner.<br><br>MCOs are required to submit Member Grievance and Appeals Reports to the state that includes the following information:<br>• Number of grievances and appeals by type.<br>• Type of assistance provided.<br>• Administrative disposition of the case.<br>• Overturn rates.<br>• Percent of grievances and appeals that did not meet timeliness requirements.<br>• Ratio of grievances and appeals per 100 members.<br>• Listing of unresolved appeals originally filed in previous quarters. |

| Element | Description/Notes |
|---|---|
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | The MCO shall report institutional utilization data for members, by age and gender in the format and per the specifications prescribed by the state:<br>• Rate of acute hospital admissions.<br>• Rate of preventable hospital admissions (e.g., pneumonia, COPD, CHF, dehydration and urinary tract infection).<br>• Rate of NF admissions.<br>• Members discharged from a NF.<br>• Members residing in NFs.<br>• Rate of chronic hospital admission.<br><br>The contract specifies the following care coordination performance measures:<br>• New members who have met with their service coordinator.<br>• New members received an assessment and had a care plan developed.<br><br>The MCO must use the following performance standards to monitor the success of program implementation and must improve its performance measure outcomes from year to year. The state will set and provide the MCO with the performance standards annually on the following 3 levels:<br>• Minimum--Minimal expected level of performance.<br>• Goal--A reachable standard for a given performance measure.<br>• Benchmark--Ultimate standard to achieve.<br><br>The MCO must show demonstrable and sustained improvements toward meeting the state set performance standards. The state will require corrective action plans and may impose sanctions on the MCOs that do not meet the minimum performance standards and do not show significant improvement. |
| 3. PIP Requirements | Contract does not require LTSS-related PIPs. |

| Element | Description/Notes |
|---|---|
| 4. EQRO Requirements | MCOs are required to:<br>• Collaborate with the EQRO to assess the quality of care and services provided to members and identify opportunities for health plan improvement.<br>• Provide all requested program-related documents and data to the EQRO.<br>• Submit any corrective action plan(s) that address identified issues requiring improvement, correction or resolution to the state and the EQRO.<br><br>The EQRO will perform an annual independent review of the quality outcomes, timeliness of, and access to, services provided by the MCO that includes:<br>• Validation of PIPs.<br>• Validation of HEDIS performance measures required by the state.<br>• A review to determine the MCO's compliance with standards established by the state which requires a state quality strategy relating to access to care, structure and operations and quality assessment and improvement.<br><br>The EQRO will also perform the following optional activities:<br>• Administration and reporting the results of the CAHPS® 3.OH Consumer Survey. The survey will be conducted annually, administered to an NCQA-certified sample of members enrolled in each MCO and analyzed using NCQA guidelines. The EQRO will provide an overall report of survey results to the state.<br>• Administration and reporting of the results of the provider satisfaction survey. The EQRO will assist the state in developing a survey tool to gauge PCPs' and specialists' satisfaction in areas such as how providers feel about managed care, how satisfied providers are with reimbursement, and how providers perceive the impact of health plan UM on their ability to provide quality care. The EQRO will provide the state with a report of findings including the raw data broken down by island. If the health plan scores low in certain areas, the state will require that the health plan initiate corrective action plans to resolve these areas of concern. The results of the provider survey will also be made available to providers. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The MCO shall use a standardized form developed by the MCO and have a process for conducting and completing the HFA. The process and HFA form shall be submitted to the state for review and approval. |

| Element | Description/Notes |
|---|---|
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>Each service coordinator's caseload cannot exceed 1,880 hours annually (FTE in the state is 2,080 hours--1,880 hours assumes 90% productivity).<br>• For non-NF LOC members, service coordinators may have up to 750 members (1:750). The assumption is that service coordinators will devote approximately 2.5 hours annually to each member in this category (1,880 hours/750 members = 2.5 hours).<br>• For NF LOC members residing in the community, service coordinators may have up to 50 members (1:50). The assumption is that service coordinators will devote approximately 37.6 hours annually to each member in this category (1,880 hours/50 members = 37.6 hours).<br>• For NF LOC members residing in an institutional setting, service coordinators may have up to 120 members (1:120). The assumption is that service coordinators will devote approximately 15.7 hours annually to each member in this category (1,880 hours/120 members = 15.7 hours).<br>• For members choosing self-direction, service coordinators may have up to 40 members (1:40). The assumption is that service coordinators will devote approximately 47 hours annually to each member in this category (1,880 hours/40 members = 47 hours).<br><br>If a mixed caseload is assigned to a care coordinator, the following formula shall be used in determining the service coordinator's mixed caseload:<br>• Number of non-NF LOC members X 2.5 hours +<br>• Number of NF LOC members residing in the community X 37.6 hours +<br>• Number of NF LOC members residing in an institutional setting X 15.7 hours +<br>• Number of members choosing self-direction X 47 hours = 1,880 hours or less. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified in main contract. |
| | **d. LTSS/acute care coordination requirements.**<br><br>The MCO is responsible for coordinating the primary, acute and long-term care services for all members and ensuring the continuity of care. The MCO shall use a patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings. |
| | **e. Risk assessment and mitigation requirements.**<br><br>The MCO shall provide members with services that are appropriate to their medical and LOC needs. Upon enrollment, the MCO shall conduct a face-to-face HFA to determine the health and functional capability of each member and the appropriate strategies and services to best meet those needs. The HFA shall take into consideration the health status (including but not limited to medication management, risk for falls, history of ER visits), environment, available supports, medical history, and social history of each member. |
| 6. Ombudsman (Function) Requirements | The state provides and oversees the activities of the ombudsman program available to all members to assure access to care, to promote quality of care and to strive to achieve member satisfaction. |

| Element | Description/Notes |
|---|---|
| 7. Quality-Related Financial Incentives | The state has developed a program to make financial payment incentives to MCOs for meeting established performance and quality goals. The state pays a financial incentive using HEDIS measurements or measures that have been audited by a vendor selected by state. MCO may be eligible for payments if performance exceeds state benchmarks for annual HBA1C testing, biennial lipid profiles testing and biennial retinal exams.<br><br>MCOs may also be eligible for performance incentive for personal assistance services if the MCO:<br>• Increases the number of members receiving personal assistance services.<br>• Increases the number of members receiving HCBS per the annual thresholds.<br>• Increases its HCBS provider network.<br>• Does not have a waiting list. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |

| Element | Description/Notes |
|---|---|
| 9. LTSS Quality Review | Each year, the MCO must submit the following reports to the state in accordance to state requirements:<br>• Evidence of the MCO's ability to expand capacity for personal assistance services.<br>• Evidence of the MCO's ability to expand capacity for HCBS.<br><br>The MCO shall annually report the need for assistance with ADLs for all members, by age and gender, and place of residence. This data will be collected in accordance with the MDS, and will include the number of members per 1,000 needing limited assistance and number of members per 1,000 needing extensive or total assistance with mobility, transfer, dressing, eating, toilet use, personal hygiene, or bathing.<br><br>Each year, the MCO must submit a QAPIP description to the state which includes program goals, objectives, work plan, timetables for implementation and accomplishments. The report must include the previous year's QAPIP report along with UM program and evaluation reports.<br><br>The MCO must also submit annually a QAPIP Evaluation, which details the activities during the previous year, analysis of the strengths and areas of improvement, a discussion of incorporating the strengths into the MCO's practices and a corrective action for each area of improvement.<br><br>Semi-annually, the MCO must report performance measure statistics according to state requirements. On an annual basis, the MCO must report an evaluation of the performance measure activity from the previous calendar year.<br><br>The MCO must submit the following reports related to LTSS utilization:<br>• Long-Term Care Services Report, which include performance measures on transfers to and from NF and community settings, acute care hospital administrations, access to ER services and those receiving supports through HCBS and institutional setting.<br>• Personal Assistance Services Report, which include names of members assessed to need personal assistance services and those assessed who are receiving the service.<br>• HCBS Report, which include members assessed to need HCBS and those assessed who are receiving the service. |

ADL = activity of daily living
CAHPS = Consumer Assessment Health Care Providers and Systems
CHF = congestive heart failure
CI = critical incident
CIO = Chief Information Officer

COPD = chronic obstructed pulmonary disease
EQRO = external quality review organization
ER = emergency room
FTE = full-time equivalent
HCBS = home and community-based services

HEDIS = Health Effectiveness Data and Information Set
HFA = Health and Functional Assessment
IT = information technology

LOC = level of care
LTSS = long-term services and supports

MCO = managed care organization
NCQA = National Committee on Quality Assurance
NF = nursing facility
PCP = primary care provider/physician
PIP = performance improvement project

QAPIP = Quality Assessment and Performance Improvement Plan
QExA = QUEST Expanded Access
QI = quality improvement
QM = quality management
RN = registered nurse

UM = utilization management

# APPENDIX E. ILLINOIS INTEGRATED CARE PROGRAM

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Illinois Department of Healthcare and Family Services (HFS) |
| Program | Integrated Care System Program |
| Inception | May 1, 2011 |
| Year LTSS Added | Since inception. |
| Medicaid Authority | 1915(c) |
| # Enrolled | 39,487 (as of August 2013) |
| Group Enrolled | Aged, Blind Disabled who are:<br>• Age 19 and older.<br>• Non-Medicare eligible older adults and adults with disabilities receiving Medicaid (case numbers beginning with 01, 91, 02, 92, 03, 93) including all HCBS waiver enrollees. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCOs are required to have a full-time QM Coordinator who shall be a licensed clinician and will be responsible for directing the activities of the QI staff in monitoring and auditing the MCO's health care delivery system to meet the state's goal of providing health care services that improve the health status and health outcomes of enrollees. The MCO shall also have a Medical Director who is responsible for managing the MCO's quality program. The Medical Director shall also attend all quarterly QA meetings. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>The MCO shall engage in credentialing and re-credentialing of providers, monitor providers and include a plan for provider review in the QA plan. The MCO shall credential providers in accordance with NCQA credentialing standards as well as applicable HFS, state and federal requirements. Re-credentialing shall occur every 3 years.<br><br>MCOs shall perform QA evaluations of provider practices, which shall include monitoring of enrollee accessibility to ensure linguistic and physical accessibility. MCOs shall support providers in achieving accessibility.<br><br>The MCO QA plan shall include plan for provider review. The written description shall document how physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and MCO staff regarding performance and enrollee results will be provided. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>MCOs shall have a full-time Care Coordination and DM Program Manager who shall be a RN licensed, or other professional as approved by the state. The Care Coordination and DM Program Manager will direct all activities pertaining to Care Management and Care Coordination and monitor the utilization of enrollees' physical health and behavioral health treatments. |

| Element | Description/Notes |
|---|---|
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>Not specific to quality. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs are required to have a formal process for reporting incidents that may indicate abuse, neglect or exploitation of an enrollee. This will include training of all employees on the signs of abuse and neglect and what to do if suspected and information on the appropriate reporting agency. The MCO shall provide the state with its protocols for reporting suspected abuse and neglect at the Readiness Review. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>MCOs shall establish and maintain a procedure for reviewing grievances registered by enrollees. All grievances shall be registered initially with the MCO and may later be appealed to the state. The MCO's procedures must:<br>• Be submitted to the state in writing and approved in writing by the state.<br>• Provide for prompt resolution.<br>• Assure the participation of individuals with authority to require corrective action.<br><br>MCOs must have a Grievance Committee for reviewing Grievances registered by its enrollees and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:<br>• Informal process to handle grievances internally.<br>• Formally structured grievance system compliant with federal regulations, including an expedited process.<br>• Formally structured grievance committee that includes an enrollee.<br>• Final decision can be appealed to the department.<br>• Summary of grievances, responses and decisions submitted to the state quarterly.<br>• Enrollee can appoint someone to represent them throughout the grievance process.<br><br>The MCO shall have a full-time Compliance Officer who shall oversee the MCO's compliance plan and the complaint, grievance and fair hearing process, and ensure and verify that fraud and abuse is reported in accordance with the federal guidelines. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | Several performance measures address LTSS including hospital admissions due to urinary tract infections and bacterial pneumonia, pressure ulcers and community retention rate for long-term care and HCBS enrollees. |
| 3. PIP Requirements | MCOs are required to conduct PIPs that are focused on health outcomes and enrollee satisfaction. The MCO must submit PIPs to the state for approval. |

| Element | Description/Notes |
|---|---|
| 4. EQRO Requirements | MCOs are required to cooperate with the process conducted by the EQRO. MCOs shall address the findings of the external review through its QA Program by developing and implementing performance improvement goals which shall be documented in the next quarterly report submitted by MCO following the EQRO's findings. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>MCOs are required to use DON tool to determine eligibility (LOC) for NF and HCBS waivers for individuals with disabilities, HIV/AIDS, brain injury, supportive living and the elderly. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>Caseloads of Care Coordinators shall not exceed the following standards:<br>• 50:1 High risk enrollees identified as needing intensive Care Management services.<br>• 250:1 Moderate risk enrollees identified as needing supportive Care Management services. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified. |
| | **d. LTSS/acute care coordination requirements.**<br><br>MCO are required to establish a community-based ICT for those enrollees identified as requiring Care Management services. The ICT shall consist of an assigned Care Coordinator, community liaison, provider service representative, and have the support of the MCO's medical staff. ICT strategies will include:<br>• Conducting outreach and education about the development and purposes of the enrollee Care Plan.<br>• Assigning a Care Coordinator who has experience most appropriate to support enrollee.<br>• Using motivational interviewing techniques.<br>• Explaining alternative care options.<br>• Educating enrollee and caregivers about available resources.<br>• Developing an enrollee Care Plan.<br>• Providing the enrollee with a copy of the enrollee Care Plan.<br>• Coaching the enrollee to have constructive conversations with the enrollee's PCP.<br><br>If an enrollee is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, the MCO is required to assume responsibility for the management of such care and shall be liable for all claims for covered services from that date. For hospital stays that would otherwise be reimbursed under the Medicaid Program on a per diem basis, the MCO's liability shall begin on the effective date of enrollment. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the Medicaid Program on a DRG basis, the MCO will have no liability for the hospital stay. |

| Element | Description/Notes |
|---|---|
| | **e. Risk assessment and mitigation requirements.**<br><br>The MCO shall have as a goal that an enrollee has an enrollee Care Plan for HCBS Waiver services that allows the enrollee to have choice while also protecting the enrollee's safety. When a situation arises that requires negotiated risk for an enrollee, the MCO will work with the enrollee to make the enrollee aware of potential risks and make appropriate referrals if safety is a concern.<br><br>All enrollees are to be stratified as low to no risk, moderate risk or high risk. The MCO is required to conduct outreach to all enrollees categorized as high risk and moderate risk to conduct a risk assessment on these enrollees.<br><br>MCOs are required to incorporate the results of the risk assessment into the enrollee Care Plan. Enrollee Care Plans that include negotiated risks shall be submitted to MCO's Medical Director for review. Negotiated risks shall not allow or create a risk for other residents in a group setting.<br><br>The MCO's goals, benchmarks and strategies for managing the care of enrollees in its traditional DM programs shall be incorporated in and included as part of the Care Management program. The MCO shall use population and individual-based tools and real-time enrollee data to identify an enrollee's risk level. These tools and data shall include, but not be limited to, the following:<br>• HRQ;<br>• Predictive Modeling and CORE;<br>• Surveillance Data. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | The state has established an incentive pool from which MCOs may earn payments based on its performance with respect to specific quality metrics. To fund the pool, each month the state withholds a portion of the MCOs capitation rate. The MCO will not be eligible to receive any incentive pool payments if it fails to meet a minimum performance standard. (There are financial sanctions if performance data, PIPs or information on improvement efforts are not submitted.) |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | Reporting for enrollees in NFs and enrollees receiving HCBS waiver services include:<br>• Maintenance in or movement to community living.<br>• Number of hospitalizations and length of hospital stay.<br>• Falls resulting in hospitalizations.<br>• Behavior resulting in injury to self or others.<br>• Enrollee non-compliance of services.<br>• Medical errors resulting in hospitalizations.<br>• Occurrences of pressure ulcers, weight loss, and infections. |
| 10. Other | The MCO is not entitled to any enrollment until the state is satisfied that MCO is ready to provide services to enrollees in a safe and efficient manner. |

| Element | Description/Notes |
|---|---|
| 11. Other | MCOs are required to provide clinical practice guidelines and best practice standards of care for coordination of community support and services for enrollees in HCBS waivers; community reintegration and support; and long-term care residential coordination of services. |

AIDS = Acquired Immunodeficiency Syndrome
CI = critical incident
CORE = Consolidated Outreach and Risk Evaluation
DM = disease management
DON = determination of need

DRG = diagnosis-related group
EQRO = external quality review organization
HCBS = home and community-based services
HFS = Illinois Department of Healthcare and Family Services
HIV = Human Immunodeficiency Virus

HRQ = Health Risk Questionnaire
ICT = Integrated Care Team
IT = information technology
LOC = level of care
LTSS = long-term services and supports

MCO = managed care organization
NF = nursing facility
PIP = performance improvement project
QA = quality assurance
QM = quality management

RN = registered nurse

# APPENDIX F. KANSAS KANCARE

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Kansas Department of Health and Environment (KDHE)<br>NOTE: Kansas opted to write a very short contract (see 01 Kansas Sunflower Contract for sample). The contract incorporates by reference all of the RFP documents. |
| Program | KanCare |
| Inception | January 2013 |
| Year LTSS Added | Per 2012 state legislation, HCBS for individuals with IDD are not to be provided under a managed care system until January 1, 2014. A pilot demonstration program will be developed for this population between January 1, 2013 and January 1, 2014. |
| Medicaid Authority | Seeking a global 1115 waiver. |
| # Enrolled | 26,000 (projected for January 1, 2014) |
| Group Enrolled | • Children with autism;<br>• Children and adults with DD;<br>• People ages 16-64 with PD;<br>• Medically fragile children ages 0-22 dependent on intensive medical technology (TA);<br>• People ages 16-64 with TBI;<br>• People 65 and older who are functionally eligible for NF (FE);<br>• Children who are SED.<br><br>Per 2012 state legislation, HCBS for individuals with IDD are not to be provided under a managed care system until January 1, 2014. A pilot demonstration program will be developed for this population between January 1, 2013 and January 1, 2014. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCOs are required to have a full-time QM director who is responsible for quality activities. This person shall have relevant experience in QM for physical and/or behavioral health care quality. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs shall demonstrate that providers are credentialed as prescribed in federal regulations and follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with MCOs using the state's Standardized Credentialing Application. MCOs shall establish procedures to ensure that network providers comply with all timely access requirements and be able to provide documentation demonstrating monitoring. MCOs shall regularly monitor providers to ensure compliance and shall take corrective actions if a provider is found to be non-compliant. |

| Element | Description/Notes |
|---|---|
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>MCOs shall be responsible for the management, coordination, and continuity of care for all members and shall develop and maintain policies and procedures to address this responsibility. The MCO shall have systems in place to ensure well-managed care including at a minimum:<br>• Management and integration of health care through primary provider/other means.<br>• Provision of systems to assure referrals for medically necessary, specialty, secondary and tertiary care and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.<br>• Provision of systems to assure provision of care in emergency situations, including an educational process to help assure that members know where and how to obtain medically necessary care in emergency situations.<br>• Monitoring coordination of care among PCPs, specialists, behavioral health providers, and long-term care providers.<br>• Maintaining performance-based outcomes in NFs for care coordination including case management.<br>• Performing age and gender specific preventive health care management services in accordance with current best practices, having mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance.<br>• Monitoring members with ongoing medical or behavioral health conditions.<br>• Identifying members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home.<br>• Maintaining and operating a formalized hospital and/or institutional discharge planning program.<br>• Coordinating hospital and/or institutional discharge planning that includes post-discharge care, as appropriate.<br>• Maintaining an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member.<br><br>There are also special requirements for care coordination for members with complex needs. The state intends to procure services that promote patient-centered care and improve health outcomes for the entire population, but particularly for high risk, high service utilizes and other high cost individuals with complex needs. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO shall submit a plan to the state that details how it will use IT to improve coordination and integration of care, promote prevention and wellness, and improve quality through appropriate sharing of clinical and administrative data among providers and to the state. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs shall carry out activities that are consistent with state initiatives to reduce CIs. |

| Element | Description/Notes |
|---|---|
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>MCOs shall utilize and comply with all terms of the state's EVV System. The EVV system will be used to monitor the receipt and utilization of HCBS. This system logs the arrival and departure of an individual provider staff person or worker, verifies the identity of the staff person providing the service to the member, and provides immediate notification to the MCO if a provider does not arrive as scheduled.<br><br>The MCO shall ensure that the EVV system creates and makes available on at least a daily basis an electronic claims submission file and shall monitor and use information from the EVV system to verify that services are provided as specified in the POC and in accordance with the established schedule. This includes the amount, frequency, duration, and scope of each service and that services are provided by the authorized provider/worker. The EVV system must also identify service gaps, including late and missed visits. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO is required to provide a toll-free telephone number for members to call who have inquiries, questions, grievances, and etc. This line shall also be used to monitor:<br>• Information provided to beneficiaries;<br>• Grievances;<br>• Timely access;<br>• Coordination/continuity;<br>• Quality of care.<br><br>The data are used to monitor the above topics by obtaining information from the members, resolving issues, identifying and addressing trends. If deficiencies are noted the MCO must perform corrective action until compliance is met.<br><br>A grievance may be received by telephone, voice mail, e-mail, written communication or by a person. The MCO is responsible for documenting, investigating and resolving all grievances in a courteous and prompt manner. The MCOs shall establish an internal grievance and appeal process to identify record, investigate, resolve and report grievances. The grievance process must be in full compliance with all applicable state and federal laws and shall not supplant, delay, or hinder the fair hearing/appeal process.<br><br>MCOs must provide a system to track and document all grievances. The grievance tracking system shall provide operational and management information at various levels, show resolution, measure and track timeframes, allow referrals to other entities and allow inquiry into multiple fields. MCOs shall also develop a database extract file that can be imported into the state fiscal agent's grievance database. |
| | **h. Other.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| 2. LTSS Performance Measures Requirements | The state has multiple performance measures. Some are targeted for specific 1915(c) HCBS waiver populations including the following:<br>• Children with autism;<br>• Children and adults with DD;<br>• People ages 16-64 with PD;<br>• Medically fragile children age 0-22 dependent on intensive medical technology (TA);<br>• People ages 16-64 with TBI;<br>• People 65 and older who are functionally eligible for NFs (FE);<br>• Children who are SED.<br><br>Similar HCBS waiver performance measures in the domains of access, eligibility, POC development, choice, health and welfare, financial accountability and customer satisfaction are required for each of the populations. Additionally, LTSS-specific performance measures include the following:<br>• Percentage of members reporting their physical health as good within 1 standard deviation of the mean.<br>• Percentage of members reporting they are connected to the people who support them the most within 1 standard deviation of the mean.<br>• Percentage of members reporting they are doing what they want for their work within 1 standard deviation of the mean.<br>• Percentage of adults with an SPMI who report having a place to live that is comfortable for them.<br>• Percentage of re-admissions at 30 days, 90 days and 1 year from last discharge from:<br>- State MH hospitals, alternatives to state MH hospitals, and Medicaid-funded community hospital psychiatric inpatient programs for children and youth;<br>- State MH hospitals and Medicaid-funded community hospital inpatient programs for adults;<br>- NFs for MH;<br>- Psychiatric residential treatment facilities.<br>• Average Length of Stay for youth admitted to psychiatric residential treatment facility will be 100 days or lower.<br>• The MCO will ensure providers offer timely initial appointments. 85% of members will be offered an initial appointment within 10 calendar days.<br>• The MCO will maintain the following access standards for screening for institutional care:<br>- Post-stabilization 1 hour within 1 hour from initial contact to arrival of provider in an ER;<br>- Emergent immediate within 1 hour urgent 24 hours from referral.<br>• The MCO will ensure that 95% of appeals are resolved as expeditiously as the member's health condition requires. |
| 3. PIP Requirements | Each MCO must submit new data on at least 2 PIPs annually to the state, though not necessarily 2 new PIPs per year. The PIPs must be approved by the state prior to implementation. The MCOs shall identify HEDIS, NOMS, CMS approved HCBS Waiver Performance Measures and other benchmarks identified by the state and set achievable performance goals for each of its PIPs. |

| Element | Description/Notes |
|---|---|
| 4. EQRO Requirements | MCOs are required to cooperate and participate in EQRO activities in accordance with state protocols. The EQRO conducts annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services provided by the MCO. MCOs are required to collaborate with the EQRO to develop studies, surveys and other analytic activities to assess the quality of care and services provided to members and to identify opportunities for improvement. MCOs must also work collaboratively with the state and the EQRO to annually measure performance measures. MCOs shall respond to recommendations made by the EQRO within the timeframe established by the EQRO. The purpose of the EQRO is to:<br>• Provide the state with an independent assessment of the quality of care delivered to members.<br>• Resolve identified problems or contribute to improving the care of all members.<br>• Measure MCO compliance with contract requirements.<br><br>MCOs are required to provide full co-operation with the EQRO to assure quality and accessibility of health care in the appropriate setting to members including the validation of PIPs and performance measures. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>SA: KCPC screening and assessment tool which is based on ASAM criteria.<br><br>DD: DD Profile is an assessment tool designed to provide information concerning an individual's functional abilities in 3 areas: adaptive functioning, maladaptive behaviors and health.<br><br>FE: Utilizes FE Uniform Assessment Instrument to determine eligibility for FE waiver services. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>The MCO is responsible for tracking LOC re-determinations to ensure they are conducted at least annually following the process as provided by the state. Also annual face-to-face reassessments are required. |
| | **d. LTSS/acute care coordination requirements.**<br><br>The state provides funding to local health departments for the provision of health care services to low income individuals. The MCO shall make a reasonable effort to subcontract with any local health care provider receiving funds from Titles V and X of the Social Security Act. Close co-operation with these entities is strongly encouraged. The MCO must have written policies and procedures for assigning each of its members to a PCP/health home. |

| Element | Description/Notes |
|---|---|
| | **e. Risk assessment and mitigation requirements.**<br><br>MCOs shall have programs and processes in place to address the preventive and chronic health care needs of all members. MCOs shall implement processes to assess, monitor, and evaluate services to all subpopulations, including, but not limited to the ongoing special conditions that require a course of treatment or regular care monitoring, type of disability or chronic condition, race, ethnicity, gender, and age. A heath risk assessment shall be conducted and consist of the following minimum components:<br>• Total cholesterol level;<br>• HDL cholesterol level;<br>• LDL cholesterol level;<br>• TC/HDL ratio;<br>• Triglycerides;<br>• Glucose level;<br>• Blood pressure check;<br>• Waist circumference measurement;<br>• Height measurement;<br>• BMI calculation;<br>• Depression screening;<br>• Identification of allergy history;<br>• Medication use discussion;<br>• Complete age-appropriate EPSDT screenings.<br><br>Information collected shall also include demographic information and current health and behavioral health status to determine the need for care management, behavioral health services, or any other health or community services. |
| 6. Ombudsman (Function) Requirements | None specified. |

| Element | Description/Notes |
|---|---|
| 7. Quality-Related Financial Incentives | The state has a P4P program. During the first contract year, 6 performance measures are selected to measure the MCO's performance during implementation and the transition of members to the MCO. 3% of the total capitation payments are held back for the purpose of incentive payments to MCOs meeting the higher levels of performance. These performance standards require MCOs to exceed the minimum performance standard required for contract compliance and incentivize the MCOs to perform at a higher level in 6 areas determined by the state to be critical for successful integration of members into the new program. The year 1 operational measures are under the following domains:<br>• Timely claims processing;<br>• Encounter data submission;<br>• Credentialing;<br>• Grievances;<br>• Appeals;<br>• Customer Service.<br><br>Different measures from service data are used for years 2 and 3. MCOs who believe they can exceed the acceptable benchmark standard will be provided an opportunity to create and present additional performance targets and appropriate incentives. The state hopes to add measures which focus on patient outcomes, health and functional status. The state is particularly interested in measures which address smoking cessation and obesity rates. Any plan for additional incentives must be submitted by the MCO and the state reserves the right to accept, reject, or modify any additional incentive plan proposed by an MCO.<br><br>Measures related to the HCBS waiver for individuals with IDD will be developed by the state with MCO input and will be allowed to have an additional year of benchmarking. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | Quarterly report on long-term care service providers.<br><br>Monthly institutional discharge reports (including those discharged from NFs).<br><br>Monthly service authorizations, service denials, and pending service authorizations (by program as specified by the state).<br><br>Monthly utilization of services by service type and average service utilization (by program as specified by the state). |

ASAM = American Society of Addiction Medicine
BMI = body mass index
CI = critical incident
CMS = Centers for Medicare and Medicaid Services
DD = developmental disability

EPSDT = Early and Periodic Screening, Diagnosis, and Treatment Program
EQRO = external quality review organization
ER = emergency room

EVV = electronic visit verification
FE = frail elderly

HCBS = home and community-based services
HDL = high-density lipoprotein
HEDIS = Health Effectiveness Data and Information Set
IDD = intellectual and developmental disabilities
IT = information technology

KCPC = Kansas Client Placement Criteria
KDHE = Kansas Department of Health and Environment
LDL = low-density lipoprotein
LOC = level of care
LTSS = long-term services and supports

MCO = managed care organization
MH = mental health
NF = nursing facility
NOMS = National Outcome Measurement System
P4P = pay-for-performance

PCP = primary care provider/physician
PD = physical disability
PIP = performance improvement project
POC = plan of care
QM = quality management

RFP = request for proposal
SA = substance abuse
SED = serious emotional disturbance
SPMI = serious and persistent mental illness
TBI = traumatic brain injury

# APPENDIX G. MASSACHUSETTS SENIOR CARE OPTIONS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Massachusetts MassHealth, Office of Long Term Care, Executive Office of Health and Human Services (EOHHS) |
| Program | Massachusetts Senior Care Options |
| Inception | 2004 |
| Year LTSS Added | None specified. |
| Medicaid Authority | 1915(a)/(c) |
| # Enrolled | 15,568 (2012) |
| Group Enrolled | Seniors |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The SCO is required to have the following staff designated to implement the SCO's quality program:<br>• SCO Director--Oversees all activities by the SCO and its subcontractors, including but not limited to, coordinating with the SCO's QM director, medical director, geriatrician, and behavioral health clinician.<br>• QM Director--An identified senior level director to oversee all QM and performance improvement activities.<br>• Medical Director--A licensed medical director with geriatric expertise and experience in community and institutional long-term care who will be responsible for establishing medical protocols and practice guidelines to support the program.<br>• Geriatrician--A licensed geriatrician who will be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support a geriatric model of practice.<br>• Behavioral Health Clinician--A qualified behavioral health clinician, with expertise in geriatric service, who will be responsible for establishing behavioral health protocols and specialized support to PCPs and PCTs. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to develop a written protocol that addresses credentialing, re-credentialing, certification, and performance appraisal processes for providers. The protocol must also include enrollee complaints and appeals, results of quality reviews, UM information, and enrollee surveys. The MCO must have a written protocol that includes:<br>• Mechanisms for detecting under utilization and over utilization of services.<br>• Resource utilization of services, including specialty and ancillary services.<br>• Clinical performance measures on structure, process, and outcomes of care.<br>• IDT performance, including resolution of SP disagreements.<br>• Enrollee experience and perceptions of service delivery.<br>• Timely access. |

| Element | Description/Notes |
|---|---|
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>MCOs are required to have care coordinators (GSSCs) employed by ASAPs. GSSCs participate in the initial and ongoing assessments of enrollees and also arrange, coordinate, authorize and monitor LTSS. The GSSC also track the provision and functional outcomes of community long-term care services, according to the SP. The MCO is required to monitor the ASAP to ensure that the performance and qualification requirements of the GSSC are met. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO is required to have an IT system that can adequately interface with the state's information systems. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>MCOs are required to develop a protocol to address elder abuse/neglect that includes protocols for preventing, identifying, treating and reporting suspected abuse and neglect, of enrollees. The protocol should also address coordination between PCP and protective services.<br><br>The MCO is also required to deliver incident reports to the state on the next business day after the MCO receives incident notification. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>SCOs must establish qualifications for a GSSC and provide a GSSC through a contract with 1 or more of the ASAPs designated by the state that operate in the SCOs service area. The GSSC is responsible for arranging, coordinating authorizing and monitoring the provision of appropriate community long-term care and social support services. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO is required to have a system in place for timely acknowledgement and response of complaints and assistance to the enrollee. Enrollees have the right to file appeals regarding adverse actions taken by the MCO to deny, reduce, terminate, delay or suspend a covered service.<br>• Enrollee may file an internal appeal within 60 days of the receipt of the written denial notice. Enrollee must exhaust internal appeal processes before they go to external appeal by the CMS Independent Review Entity. An enrollee may also request and external review by the State Board of Hearings.<br>• On a monthly basis, the SCO must report the number and types of complaints filed by enrollees specifying how and in what timeframes they were resolved. The MCO must cooperate with the state to implement improvements based on the findings of these reports.<br>• The SCO must report the number, types, and resolutions of appeals filed, including, for external appeals, whether the external review was by the CMS Independent Review Entity or by the State Board of Hearings. |
| | **h. Other.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| 2. LTSS Performance Measures Requirements | Percent of enrollees diagnosed with dementia who are receiving geriatric support services. |
| 3. PIP Requirements | The SCO must annually develop at least 2 specific PIPs in the Primary Care, long-term care, or behavioral health areas. The SCO must provide the state with reports on progress toward reaching established goals. |
| 4. EQRO Requirements | The SCO must also participate in annual external quality reviews conducted by the EQRO. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>Upon enrollment, and as appropriate thereafter, SCOs must perform initial and ongoing assessments using an assessment tool approved by the state. This process will identify all of an enrollee's needs. SCOs must record the results of all assessments in the Centralized Enrollee Record and communicate the results to the enrollee's provider network in a timely manner. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>Upon enrollment, SCOs must perform initial and ongoing needs assessments needs at least once every 6 months and or whenever an enrollee experiences a major change. Enrollees who require complex care SCOs must perform assessments at least quarterly. |
| | **d. LTSS/acute care coordination requirements.**<br><br>SCOs must ensure linkages among the PCP, the PCT, and any appropriate acute, long-term care, or behavioral health providers to keep all parties informed about utilization of services. SCOs must ensure that the PCP or the PCT integrates and coordinates services including protocols for:<br>• Individualized POC.<br>• Generating or receiving referrals and recording and tracking the results of referrals.<br>• Providing or arranging for second opinions.<br>• Sharing clinical and individualized POC information.<br>• Determining conditions and circumstances under which specialty services will be provided.<br>• Tracking and coordination of enrollee transfers from 1 setting to another.<br>• Obtaining and sharing individual medical and care planning information among the enrollee's caregivers in the provider network. |
| | **e. Risk assessment and mitigation requirements.**<br><br>SCOs must have protocols which address monitoring and risk assessment mechanisms to identify enrollees at risk of hospitalization for pneumonia, dehydration, injuries from falls, skin breakdown, loss of informal caregiver, and history of non-compliance with treatment programs. In addition, SCOs must develop monitoring and risk assessment mechanisms that assist the PCP or PCT to identify enrollees at risk of institutionalization. SCOs may contract with ASAPs to conduct risk assessment activities regarding non-medical service needs for enrollees without complex care needs. |

| Element | Description/Notes |
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| 6. Ombudsman (Function) Requirements | SCOs must employ ESRs trained to answer enrollee inquiries and concerns and be available to enrollees to discuss and provide assistance with resolving complaints. SCOs must compile and analyze all complaints at least annually must include an examination of frequency by type of complaint and the satisfaction or dissatisfaction of enrollees with complaint resolution.<br><br>In addition, SCOs are required to provide information to enrollees regarding contacting an external Ombudsman. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | The SCO must administer an annual survey to all enrollees and report the results to the state. The survey must include:<br>• Quality and performance indicators including:<br>- Information on enrollee satisfaction;<br>- Availability, accessibility, and acceptability of services;<br>- Information on health outcomes and other performance measures.<br>• Information about enrollee appeals and their disposition.<br>• Member experience of care.<br><br>The SCO must conduct 1 survey or focus group with each of the following groups:<br>• Non-English speaking enrollees to assess their experience with the contractor's ability to accommodate their needs.<br>• Persons with PD to assess their experience with the SCOs ability to meet their needs.<br>• Enrollees from a minority ethnic group served by the SCO to assess their experience with the SCO's ability to provide culturally sensitive care and support to family members and caregivers of enrollees.<br>• Family members and significant caregivers of enrollees to assess the SCO's ability to support family members and significant others. |
| 9. LTSS Quality Review | SCOs are required to produce the follow reports:<br>• Clinical data including specific HEDIS measures and state specific measures regarding preventive medicine, acute and chronic disease, and enrollees diagnosed with dementia.<br>• Complaints and appeals.<br>• Disenrollment rate.<br>• Annual report of voluntary enrollment rate and reasons.<br>• Annual reports on rates of preventable hospitalizations, admissions and discharges from nursing homes facilities.<br>• Community health service utilization in units and per 1,000 enrollees for services such as personal care, hospice and adult day care. |
| 10. Other | **GSSC**--SCOs must establish qualifications for a GSSC and provide a GSSC through a contract with 1 or more of the ASAPs designated by the state that operate in the SCOs service area. The GSSC is responsible for the following activities:<br>• As a member of the PCT, participate in Initial and Ongoing Assessments of the health and functional status of enrollees.<br>• Arrange, coordinate and authorize the provision of appropriate community long-term care and social support services.<br>• Monitor the appropriate provision and functional outcomes of community long-term care services.<br>• Track the appropriate provision and functional outcomes of community long-term care services. |

| Element | Description/Notes |
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| 11. Other | SCOs must conduct an evaluation of the effectiveness of health promotion and wellness activities for enrollees on each anniversary of the start date of the contract, specifying the costs, benefits, and lessons learned. SCOs must also implement improvements based on the evaluation, including, as appropriate, continuing education programs. |
| 12. Other | SCOs must ensure access to 24-hour emergency services for all enrollees, whether they reside in institutions or in the community. |
| 13. Other | **Program Initiatives**--The SCO must have and comply with written protocols and a reporting system to:<br>• Minimize unnecessary or inappropriate hospital admissions.<br>• Ensure that enrollees who are admitted to an institution receive the Interdisciplinary Discharge Planning and implementation processes that begin at the point of admission to the hospital or NF.<br>• Provide cancer screening services, and the provision of appropriate follow-up services.<br>• Provide DM activities (for enrollees identified with CHF, COPD, diabetes).<br>• Manage the care for enrollees identified with dementia.<br>• Prevent, identify, and treat alcohol abuse.<br>• Prevent and treat abuse and neglect of enrollees and report incidents and actions taken. |

ASAP = aging services access points
CHF = congestive heart failure
CI = critical incident
CMS = Centers for Medicare and Medicaid Services
COPD = chronic obstructed pulmonary disease

DM = disease management
EOHHS = Massachusetts Executive Office of Health and Human Services
EQRO = external quality review organization
ESR = Enrollee Service Representative
GSSC = Geriatric Support Services Coordinator

HEDIS = Health Effectiveness Data and Information Set
IDT = interdisciplinary team
IT = information technology
LTSS = long-term services and supports
MCO = managed care organization

NF = nursing facility
PCP = primary care provider/physician
PCT = primary care team
PD = physical disability
PIP = performance improvement project

POC = plan of care
QM = quality management
SCO = senior care organization
SP = service plan
UM = utilization management

# APPENDIX H. MICHIGAN MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Michigan Department of Community Health (MDCH) |
| Program | Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program |
| Inception | 1998: 1915(b)--serving persons with mental illness and DD.<br>2002: 1915(c)--provides additional services (private duty nursing and goods/services); for subgroup of DD population. |
| Year LTSS Added | An LTSS program from inception. |
| Medicaid Authority | 1915(b) Specialty Services Waiver.<br>1915(c) HSW. |
| # Enrolled | 172,527<br>Data Source: *Section 404(1): Community Mental Health Services Support Programs Report*, May 31, 2013. |
| Group Enrolled | Persons with mental illness, persons with DD and dually diagnosed. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>PIHPs are the MCO entities in Michigan. They are required to have a comprehensive managed care program that includes QI and utilization review. PIHPs must have an operational QAPIP accountable to a Community Mental Health Services Program Board of Directors. A designated senior official of the PIHP is responsible for the QAPIP implementation. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>Contracts entered into by the PIHPs must address QA/QI systems.<br><br>The PIHP is required to conduct annual monitoring of its provider network and subcontractors. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>Contract requires PIHPs to have a MIS that has capability to track grievances and complaints, quality indicator reporting and information on program participant access and satisfaction. |

| Element | Description/Notes |
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| | **e. CI investigation processes and associated reporting requirements.**<br><br>PIHPs must report 5 CIs to the state via the state's CI reporting site on the state's website:<br>• Suicide;<br>• Non-suicide death;<br>• Emergency Medical treatment due to Injury or Medication Error;<br>• Hospitalization due to Injury or Medication Error;<br>• Arrest of Consumer.<br><br>CIs must be reported within 60 days after the end of the month in which the event occurred, except for suicide. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide.<br><br>PIHPs must notify the state immediately of deaths that occur as a result of a suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. Reports must be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced.<br><br>The PIHP or its delegate is responsible for implementing the process of the review and follow-up of sentinel events (not specified in the contract) and other CIs and events that put people at risk of harm. The PIHP or its delegate has 3 business days after a CI occurs to determine if it is a sentinel event. If the CI is classified as a sentinel event, the PIHP or its delegate has 2 business days to commence a root cause analysis of the event. Persons involved in the review of sentinel events must have the appropriate credentials.<br><br>**Mortality Reviews**--All unexpected deaths (suicides, homicides, deaths experienced by person having an undiagnosed condition, accidental deaths, deaths where there is suspicion of abuse or neglect) must be reviewed. The review includes:<br>• Screens of individual deaths with standard information (e.g., coroner's report, death certificate).<br>• Involvement of medical personnel in the mortality reviews.<br>• Documentation of the mortality review process, findings, and recommendations.<br>• Use of mortality information to address quality of care.<br>• Aggregation of mortality data over time to identify possible trends.<br><br>**Risk Event Management**--The PIHP must have a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The state will request documentation of this process when performing site visits. These events include:<br>• Actions taken by individuals who receive services that cause harm to themselves.<br>• Actions taken by individuals who receive services that cause harm to others.<br>• 2 or more unscheduled admissions to a medical hospital within a 12-month period. |

| Element | Description/Notes |
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| | **Restrictive Interventions**--On a quarterly basis, the PIHP is required to review data from a Behavior Treatment Review Committee (part of the local MH agency) where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement has been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data must include:<br>• Dates and numbers of interventions used.<br>• Settings (e.g., individual's home or work) where behaviors and interventions occurred.<br>• Observations about any events, settings, or factors that may have triggered the behavior.<br>• Behaviors that initiated the techniques.<br>• Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.<br>• Description of positive behavioral supports used.<br>• Behaviors that resulted in termination of the interventions.<br>• Length of time of each intervention.<br>• Staff development and training and supervisory guidance to reduce the use of these interventions.<br>• Review and modification or development of the individual's behavior plan.<br><br>The purpose of the Behavior Treatment Review Committee is to review and approve/disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public MH system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>PIHPs are required to verify that services reimbursed by Medicaid were furnished to enrollees by a provider. The PIHP's verification methodology must be approved by the state. The PIHP must annually submit its findings from this process and include in its report any follow-up actions that were taken as a result of the findings. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>None specified. |
| | **h. Other.**<br><br>**Emergency and After-Hours Access to Services**--PIHPs are required to provide emergency and after-hours access to services for persons experiencing a MH emergency. |

| Element | Description/Notes |
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| 2. LTSS Performance Measures Requirements | PIHPs are required to submit uniform data elements for performance measures that constitute the Michigan Mission-Based Performance Indicator System, focused on the following 4 categories:<br><br>**ACCESS PERFORMANCE MEASURES**<br>• Percent of all Medicaid adult and children beneficiaries receiving a pre-admissions screening for psychiatric inpatient care for whom the disposition was completed within 3 hours. **Standard = 95% in 3 hours**.<br>• Percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SA). **Standard = 95% in 14 days**.<br>• Percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional (MI adults, MI children, DD adults, DD children, and Medicaid SA). **Standard = 95% in 14 days**.<br>• Percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within 7 days. (All children and all adults (MI, DD) and all Medicaid SA (sub-acute detox discharges.)<br>• Percent of Medicaid recipients having received PIHP managed services (MI adults, MI children, DD adults, DD children, and SA).<br><br>**ADEQUACY/APPROPRIATENESS PERFORMANCE MEASURES**<br>• Percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least 1 HSW service per month that is not supports coordination.<br><br>**EFFICIENCY PERFORMANCE MEASURES**<br>• Percent of total expenditures spent on managed care administrative functions for PIHPs.<br><br>**OUTCOMES PERFORMANCE MEASURES**<br>• Percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with DD served by PIHPs who are in competitive employment.<br>• Percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with DD served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).<br>• Percent of MI/DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days.<br>• Annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.<br>• Percent of adults with DD served, who live in a private residence alone, or with spouse or non-relative.<br>• Percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.<br>• Percent of children with DD (not including children in the Children's Waiver Program) in the quarter who receive at least 1 service each month other than case management and respite. |

| Element | Description/Notes |
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| | **PASRR-RELATED PERFORMANCE MEASURE**<br>• PIHPs must also meet a standard of 100% whereby people who meet the OBRA Level II Assessment criteria for specialized MH services for people residing in nursing homes, as determined by MDCH shall receive PIHP managed MH services.<br><br>**ADDITIONAL PERFORMANCE MEASURES**<br>• An increased number of Medicaid children (birth through age 17 years) with SUD per 1,000 in the PIHP service area who are provided Medicaid SA specialty services and supports.<br>• An increased number of Medicaid adults (age 18 and older) with SUD per 1,000 in the PIHP service area who are provided Medicaid SA specialty services and supports.<br>• An increased percentage in FY 2011 Medicaid expenditures over the base year of FY 2006 Medicaid expenditures for children and adults with SUD.<br><br>For the following measures, each PIHP must negotiate its individual performance targets. A baseline for FY 2006 will be established. For FY 2008 no sanctions will be imposed for failure to reach target. In future years, P4P will be imposed, with the details of the P4P arrangement negotiated between state and the PIHP and included in subsequent contract amendments.<br>• An increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who are provided Medicaid MH specialty services and supports.<br>• For children with SED and DD/SED co-occurring conditions, an increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who are provided Medicaid MH specialty services and supports.<br>• For children with DD, an increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who receive MH specialty services and supports. |
| 3. PIP Requirements | Each PIHP must engage in at least 2 PIPs during the waiver renewal period. |
| 4. EQRO Requirements | The state arranges for an annual, external independent review of the quality outcomes, timeliness and access to covered services provided by PIHP. The PIHP must develop and implement performance improvement goals, objectives and activities in response to the external review findings. The state may also require separate submission of an improvement plan-specific to the findings of the external review. |
| 5. Care Coordination Requirements | None specified. |
| 6. Ombudsman (Function) Requirements | None specified. |

| Element | Description/Notes |
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| 7. Quality-Related Financial Incentives | A first and second place monetary award will be presented to a PIHP who has shown a relative improvement over the last fiscal year in the following areas:<br>• Number of enrollees engaged in meaningful employment.<br>• Number of enrollees served that are living in a private residence not owned by the PIHP or the contracted provider, either alone or with spouse or non-relative.<br>• Number of enrollees discharged from a SA detox unit and seen for follow-up within 7 days.<br><br>In order to be eligible for the award, a PIHP must not have received a non-compliance score for any site review dimension in their site review report. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | PIHPs are required to conduct periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered. The assessments must address the issues of the quality, availability, and accessibility of care. The PIHP must submit a report on an annual consumer satisfaction in August each year. More specifically, for persons with mental illness, the PIHP is required to use the MHSIP Youth and Family Survey and to conduct this survey in May of each year. Programs that the PIHP serves will be selected by the QIC* to receive the survey based on volume of units, expenditures, complaints and state site review information.<br><br>**The QIC is comprised of consumers, advocates, provider organizations, PIHPs and Community Mental Health Service Programs*. |
| 9. LTSS Quality Review | None specified. |
| 10. Other | **Non-monetary Incentives**--Should a PIHP show full compliance within a particular area or 2 full cycle site reviews, the state site review team will skip the next full review unless the state has other information that brings the PIHP's compliance into question. |
| 11. Other | **Non-monetary Sanctions**--PIHPs are required to submit a plan of correction that addresses each review dimension for which there was a finding of partial or non-compliance. If a PIHP receives a repeat citation on a site review dimension, the state site review team may increase the size of the clinical record review sample for that dimension for the next site review and/or require the program to re-undergo state approval to operate. |
| 12. Other | **Financial Sanctions**--The PIHP contract specifies that financial sanctions may be imposed to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance on performance indicator standard, repeated site review non-compliance, substantial inappropriate denial of services, or substantial or repeated health and/or safety violations. |

CI = critical incident
DD = developmental disability
EQRO = external quality review organization
HSW = Habilitation Supports Waiver
IT = information technology

LTSS = long-term services and supports
MCO = managed care organization
MDCH = Michigan Department of Community Health

MH = mental health
MHSIP = Mental Health Statistics Improvement Program

MI = mentally ill
MIS = Management Information System
OBRA = Omnibus Budget Reconciliation Act
P4P = pay-for-performance
PIHP = Pre-paid Inpatient Health Plan

PIP = performance improvement project
QA = quality assurance
QAPIP = Quality Assessment and Performance Improvement Plan
QI = quality improvement
QIC = Quality Improvement Council

SA = substance abuse
SED = serious emotional disturbance
SUD = substance use disorder

# APPENDIX I. MINNESOTA SENIOR CARE PLUS AND MINNESOTA SENIOR HEALTH OPTIONS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Minnesota Department of Human Services |
| Program | Minnesota Senior Care Plus (MSC+)<br>Minnesota Senior Health Options (MSHO) |
| Inception | 2005 (MSC+)<br>1997 (MSHO) |
| Year LTSS Added | N/A |
| Medicaid Authority | 1915(b)/(c) (MSC+)<br>1915(a)/(c) (MSHO) |
| # Enrolled | 11,995 (April 2012) (MSC+)<br>36,128 (April 2012) (MSHO) |
| Group Enrolled | Elderly (MSC+).<br>Elderly eligible for both Medicaid and Medicare Parts A & B (MSHO). |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>None specified. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>The MCO must submit annually a report to the state that includes a complete list of participating providers including name, specialty, and address. The MCO will provide information about the qualifications of MH and chemical dependency providers.<br>• The MCO shall adopt a uniform credentialing and re-credentialing process and comply with that process consistent with state regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans".<br>• For organizational providers, including NFs, hospitals, and Medicare certified home health care agencies, the MCO shall adopt a uniform credentialing and re-credentialing process and comply with that process consistent with state regulations. |

| Element | Description/Notes |
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| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>The MCO must provide a description of the Case Management System to include:<br>• A document describing how case management is being provided for community and nursing home members by county and population group including whether it is provided through contracts with local agencies or tribes, clinic or provider care systems, community agencies, health plan staff or other arrangements or through a combination of such arrangements.<br>• The most recent SNP model of care as submitted to CMS.<br>• Lists and descriptions of entities providing Care Coordination and Case Management contractors, duties of such entities or subcontractors, contracting and delegation arrangements.<br>• A description of Care Coordination and/or Case Management screening and assessment tools, timelines and follow-up processes.<br>• A description of use of protocols for management of chronic conditions including procedures for communication with clinics and physicians.<br>• A description of use of Nurse Practitioners in the care of NF residents if applicable.<br>• A description of the MCO's oversight and training of subcontractors and Care Coordinators/Case Managers, qualifications and caseloads/ratios of Care Coordinators/Case Managers.<br>• Changes and updated descriptions provided annually. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO must operate an information system that supports initial and ongoing operations and QAPIP. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives:<br>• Collect data on enrollee and provider characteristics, and on services furnished to enrollees.<br>• Ensure that data received from providers is accurate and complete by:<br>- Verifying the accuracy and timeliness of reported data;<br>- Screening or editing the data for completeness, logic, and consistency;<br>- Collecting service information in standardized formats to the extent feasible and appropriate.<br>• Make all collected data available to the state and CMS upon request. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>None specified. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO must have a Grievance System in place that includes a grievance process, an Appeal process, an expedited Appeals process and access to the state Fair Hearing and Expedited Hearing Decision system. The overall system must:<br>• Assure compliance with Medicare and Medicaid requirements.<br>• Preserve enrollees' access to all appropriate levels of Medicare and Medicaid appeals.<br>• To the extent possible, integrate both processes to make the system easier to navigate for the MSHO enrollee.<br>• MCO must maintain and make available upon request by the state its records of all Grievances, DTRs, Appeals and state Fair Hearings to include the following reports:<br>- Quarterly electronic report of all oral and written Grievances;<br>- Quarterly DTR of Service Notice report;<br>- Quarterly electronic report of all oral and written Appeals.<br><br>The Grievance System must meet requirements of state statutes. Any proposed changes to the Grievance System must be approved by the state prior to implementation. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | None specified. |

| Element | Description/Notes |
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| 3. PIP Requirements | Each year, the MCO is required to submit a written description of the PIP the MCO proposes to conduct to the state for review and approval. The proposal must be consistent with the CMS protocol entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities, Conducting Performance Improvement Projects" and state requirements. The new PIP proposal must include steps 1-7 of the CMS protocol and must be targeted to the MCO's senior populations.<br><br>Each year, the MCO must produce an interim report for each current PIP to include any changes to the project(s) protocol steps 1-7, and steps 8 and 10 as appropriate. Upon completion of each PIP, the MCO must submit a final written report to the state for review and approval. The report must include any changes to protocol steps. Each completed project must have a separate report.<br><br>The MCO is required to work with the state on developing PIPs for seniors. PIP topics should address the full spectrum of clinical and non-clinical areas associated with the MCO and not consistently eliminate any particular subset of enrollees or topics when viewed over multiple years. The MCO is encouraged to continue participation in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs. The MCO may use its Medicare QIP to meet the PIP requirements including using Medicare's measurement standards and reporting timelines. The MCO will consult with the state on the topic and interventions prior to submission to CMS. The MCO will provide the state with copies of the final QIP proposal within 15 days of submission.<br><br>The MCO shall provide the state an annual written work plan that details the MCO's proposed QA and PIPs for the year. |
| 4. EQRO Requirements | The MCO is required to cooperate with the EQRO in an annual independent, external review of the quality of services furnished by the MCO. Such co-operation includes:<br>• Meeting with the EQRO and responding to questions.<br>• Providing requested medical records and other data in the requested format.<br>• Providing copies of MCO policies and procedures, and other records, reports and/or data necessary for the external review.<br><br>To avoid duplication, the state may use information collected from Medicare or private accreditation reviews in place of a Medicaid review by the state, its agent, or EQRO. The MCO may request an exemption to the EQRO requirements from the state if the MCO meets federal requirements and is approved by the state and CMS.<br><br>The state shall allow the MCO to review a final draft copy of the EQRO Annual Technical Report prior to the date of publication. The MCO shall provide the state any written comments about the report, including comments on its scientific soundness or statistical validity, within 30 days of receipt of the final draft report. The state will include a summary of the MCO's written comments in the final publication of the report and may limit the MCO's comments to the report's scientific soundness and/or statistical validity. The MCO is required to effectively address recommendations for improving the quality of health care services made by EQRO in the Annual Technical Report for obligations under the contract. |

| Element | Description/Notes |
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| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>Within 30 calendar days of enrollment and annually thereafter, the MCO shall make a best effort to conduct a health risk assessment of each enrollee's health needs. All assessments shall be kept in the individual enrollee health record at the MCO care system or county care coordination system. The assessment should address medical, social and environmental and MH factors including the physical, psychosocial, and functional needs of the enrollee. MCOs must integrate required Medicare assessments, LTCC assessments and any additional comprehensive assessments being conducted for enrollees to the extent possible. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>MCOs shall establish policies and criteria for caseload ratios for care coordinators serving all enrollees. The MCO will submit these policies and procedures to the state for review. Criteria used to develop ratios will include but not be limited to:<br>• Non-English speaking or need for translation.<br>• Case-mix.<br>• Need for high intensity acute Care Coordination.<br>• MH status.<br>• Travel time.<br>• Lack of family or informal supports. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>For each enrollee, a care plan is implemented based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes through regular follow-up, and a process to ensure that care plans are revised as necessary. These plans must be designed to accommodate the specific cultural and linguistic needs of enrollees.<br><br>For NF residents, care coordination communication with facility staff and primary care as part of an IDT must be established to address risk areas and manage services as-needed. Routine care plan evaluations shall be conducted to support a proactive, preventive approach. More extensive evaluations may be required based on clinical needs or changes in condition.<br><br>For community enrollees, services shall be coordinated with providers based on the results of the assessment and with input from the enrollee, family members as appropriate, primary care and the care system team. Primary care for enrollees who have not had access to these services in the past must be arranged. A comprehensive reassessment shall be conducted annually or upon change of condition. Risk assessments shall be conducted annually or upon change in condition followed by a comprehensive assessment as-needed based on identified risk. A schedule for regular contact with the enrollees by the care coordinator shall be established in order to identify and monitor changes in condition. |

| Element | Description/Notes |
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| | **d. LTSS/acute care coordination requirements.**<br><br>The MCO must provide case management services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post-acute and rehabilitation services. The care coordination system must be designed to ensure communication and coordination of an enrollee's care across the Medicare and Medicaid network provider types and settings to ensure smooth transitions for enrollees who move among various settings. The system should strive to facilitate and maximize the level of enrollee self-determination and enrollee choice of services, providers and living arrangements. The care coordination system should provide each enrollee with a primary contact person who will assist the enrollee in simplifying access to services and information. The system must be designed to promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability. |
| | **e. Risk assessment and mitigation requirements.**<br><br>Within 60 calendar days of enrollment and annually for all enrollees, the MCO shall conduct a risk screening or assessment of each enrollee's health needs. The screening may be conducted by phone, mail or face-to-face. The screening should address medical, social, environmental, and MH factors. A risk assessment tool may be used with follow-up assessments conducted based on level of risk. ADLs should be included in the assessment. |
| 6. Ombudsman (Function) Requirements | The state has established a State Office of the Ombudsman for managed care enrollees. The MCO is required to inform the enrollee of options for further assistance through Office of the Ombudsman. |
| 7. Quality-Related Financial Incentives | The state withholds a portion of the rates of the MCO's payments and these funds are returned to the MCO only if, in the judgment of the state performance targets are achieved. The withheld funds will be returned to the MCO for the based on the scoring system for each of the performance targets including:<br>• Specific provider measures.<br>• Completion of and submission to state of the Care Plan audit.<br>• Timely completion of initial health risk screening or assessments.<br><br>In addition, the MCO is required to cooperate with the state to develop and implement a P4P model for chronic disease care.<br><br>The state pays the incentive payments to the MCO based on criteria established by the state. The MCOs pay the state's program administrator (private vendor) the same incentive reward payment. The program administrator then distributes the appropriate payment to the eligible MCOs based on their performance. In order to receive the annual reward, the MCO contracted clinic or medical group must have achieved optimal chronic disease care for a designated percentage of its patients, as determined by the Program Administrator. The P4P projects are limited to diabetes care and coronary/vascular disease care. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | The state conducts an annual enrollee satisfaction survey, and if necessary, the MCO shall cooperate with the entity arranged by the state to conduct the survey. The state will consult with the MCOs on the survey tool. If the MCO or any of its contracted care systems conduct an enrollee satisfaction survey, including the Medicare CAHPS, the MCO must provide the state with a copy of the survey results in a timely manner. |

| Element | Description/Notes |
|---|---|
| 9. LTSS Quality Review | The MCO must conduct an annual QAPIP evaluation consistent with state and federal regulations, including the CMS "Quality Framework for the Elderly Waiver" and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." This evaluation must review the impact and effectiveness of the MCO's QAPIP including performance standard measures and MCO's PIPs. The evaluation must also include an analysis on the impact and effectiveness of MSHO Care Coordination activities. This evaluation may be combined with the required Medicare evaluation, provided it is conducted at the Dual Eligible SNP plan level.<br><br>Any substantive changes in the Service Delivery Plan previously submitted shall be provided by the MCO to the state within 30 days of the effective date of the contract and prior to any subsequent changes made by the MCO. The state must approve all changes to the MCO's Service Delivery Plan. Each Contract Year, the MCO must provide an updated description of the Case Management System. |

ADL = activity of daily living
CAHPS = Consumer Assessment Health Care Providers and Systems
CI = critical incident
CMS = Centers for Medicare and Medicaid Services
DTR = denial, termination, and reduction

EQRO = external quality review organization
IDT = interdisciplinary team
IT = information technology
LTSS = long-term services and supports
MCO = managed care organization

MH = mental health
MSC+ = Minnesota Senior Care Plus
MSHO = Minnesota Senior Health Option
NCQA = National Committee on Quality Assurance
NF = nursing facility

P4P = pay-for-performance
PIP = performance improvement project
QA = quality assurance
QAPIP = Quality Assessment and Performance Improvement Plan
QIP = Quality Improvement Project

SNP = special needs plan

# APPENDIX J. NEW MEXICO COORDINATION OF LONG-TERM SERVICES

| Element | Description/Notes |
|---|---|
| State and Lead Agency | New Mexico Human Services Department (HSD)<br>New Mexico Aging and Long-Term Services Department (ALTSD) |
| Program | Coordination of Long-Term Services (CoLTS) |
| Inception | 2008 |
| Year LTSS Added | N/A |
| Medicaid Authority | Enrollment: 1915(b)<br>LTSS: State Plan Personal Care Option and 1915(c) |
| # Enrolled | 39,607 (March 2012) |
| Group Enrolled | Elderly, physically disabled and children with LTSS needs. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO must designate an individual within the company responsible for compliance with all the QM/QI requirements. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to have written policies and procedures for the credentialing process for individual practitioners including the MCO's initial credentialing of practitioners and subsequent re-credentialing, recertifying and/or re-appointment of practitioners as required by the state. MCOs must designate a credentialing committee or other peer review body to make recommendations regarding credentialing decisions. The MCO shall formally re-credential network providers at least every 3 years.<br><br>The MCO must also have written policies and procedures for the initial and ongoing assessment of all providers. The MCO must confirm that the provider:<br>• Is in good standing with state and federal regulatory bodies.<br>• Has been reviewed and approved by an accrediting body.<br><br>The MCO must also develop and implement standards of participation that demonstrate the provider is in compliance with provider participation requirements under federal law and regulations if the provider has not been approved by an accrediting body.<br><br>The state and the MCO shall mutually agree to a single primary source verification entity to be used by the MCO and its subcontractors in its provider credentialing process. All MCOs shall use 1 standardized credentialing form. The state shall have the right to mandate a standard credentialing application. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs are required to maintain system hardware, software, and information systems resources sufficient to provide the capacity to accept, process, maintain, and report specific information necessary to the state program administration and other contracted service arrangements, including but not limited to, data pertaining to providers, members, claims, encounters, grievance and appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures and comply with the most current federal standards for encryption of any data that is transmitted via the Internet. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The MCO shall develop and implement policies and procedures for CI reporting to include the ability to track, analyze, and report to the state as required, those reporting indicators identified by the state, specific to physical health and/or behavioral health visits handled by the PCPs that shall enable the state to determine potential problem areas, including but not limited to, quality of care, access to care, provider payment timeliness, or service delivery issues.<br><br>The MCO must:<br>• Utilize the report formats provided by the state and provide monthly analysis report findings.<br>• Utilize critical indicator monitoring for early identification and interventions of quality of care and/or health and safety issues.<br>• Analyze the data including the identification of any significant trends.<br>• Address negative trends in the analysis and develop appropriate CQI initiatives.<br>• Conduct annual provider reviews of all network providers on data collected on medication management to identify harmful practices. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO is required to have a grievance, appeal system, fair hearing and an expedited resolution of appeals process that is responsive to concerns raised by members and meets all the state requirements in regards to notices to providers on the grievance policies to providers; reasonable accommodations to assist members in submitting a grievance; timeframes confirming receipt of a grievance, conducting the investigation and completing the resolution process; and, notice to parties affected by the decision.<br><br>The MCO must name a specific individual designated as the Medicaid Member Grievance Coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action. Under certain state-specified circumstances, the MCO must continue covered services and other benefits while the appeal and fair hearing process is pending.<br><br>The MCO must maintain all grievance and appeals files in a secure, designated area and be accessible to the state upon request. The MCO must provide the state with monthly reporting of all provider and member Grievances, Appeals, and Fair Hearing using the state-specified reporting template and a monthly report of the analysis of all grievances to include the identification of any indications of trends as well as any interventions taken to address those trends. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | In collaboration with the state, the MCO implements performance measures and tracking measures of HCBS delivery and activities designed to improve coordination of services. |
| 3. PIP Requirements | LTSS PIPs not specified.<br><br>As part of the MCO's annual QM work plan which must be approved by the state, the MCO must specify PIPs, plans and activities consistent with federal and state laws and regulations. |
| 4. EQRO Requirements | The state retains the services of an EQRO and the MCO must cooperate fully with the EQRO. The EQRO will audit a statistically valid sample of the MCO's physical health and long-term care services, and decisions including authorizations, reductions, terminations and denials to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. The EQRO will also audit the MCO's QM/QI program and review performance measures and PIPs, based on federal criteria. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>None specified. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>MCOs are required to have Service Coordinators to meet face-to-face or telephonically with those individuals receiving long-term support services as frequently as appropriate to support the member's goals and to foster independence and in accordance with the service or treatment plan developed by the Service Coordinator consistent with professional standards or care and agreed to by the member. At a minimum, Service Coordinators meet face-to-face with members at least once quarterly and a telephone contact shall occur at least once monthly. |
| | **d. LTSS/acute care coordination requirements.**<br><br>MCOs are required to develop and implement written policies and procedures that ensure that health and social service delivery is coordinated across providers, service systems, and varied levels of care maximizing the member's ISP goals, as well as outcomes and that ensure that all transitions of care from institutional to community-based services be proactively coordinated with all providers involved in the member's SP. |
| | **e. Risk assessment and mitigation requirements.**<br><br>MCOs are required to identify actual or potential health, behavioral or personal safety risk to members during the initial and ongoing comprehensive assessment process, discuss such risks with the member and interventions to mitigate such risks. The MCO must conduct home safety evaluations for each member annually or more frequent if needed. MCO's must coordinate with the member's PCP, acute and long-term service practitioners. MCOs must also identify special risks to members transitioning from institutional to home and community-based settings.<br><br>MCO must also identify system-wide risks and aggregation of risk trends. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | The state may provide incentives to the MCO that receives exceptional grading during the procurement process and for ongoing performance for QA standards, performance indicators, enrollment processing, fiscal solvency, access standards, encounter data submission, reporting requirements, Third Party Liability collections and marketing plan requirements as determined. The state determines whether the MCO has met, exceeded, or fallen below any and all such performance standards. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | As part of the QM/QI program, the MCO must conduct at least 1 annual survey of member satisfaction with input from the Consumer Advisory Board and the state to assess member satisfaction with quality, availability, and accessibility of services including state-specific topics of at least 1 question each relating to the ability of ISHCN to participate in their SP and goals; the convenience of service locations and appointment times for members; service coordinator helpfulness getting members what they need; level of satisfaction with MCOs; satisfaction with member participation in treatment decisions; and degree to which members feels they can manage day-to-day lives.<br><br>The state specifies survey administration criteria and dissemination of the results. |

| Element | Description/Notes |
|---|---|
| 9. LTSS Quality Review | The MCO must be able to provide QI related reports for various public forums that are easily understandable to the lay person and collect, manage and report to the state, data necessary to support the QI activities.<br><br>MCOs must base management and service delivery on principles of CQI/TQM and submit annually a QM/QI work plan that includes the following:<br>• Acute and long-term health and social service delivery and coordination.<br>• Scope of the objectives, projects, or activities planned, timeframes and data indicators for tracking performance.<br>• PIPs, plans and activities consistent with federal and state laws and regulations.<br>• At least 1 member safety indicator.<br>• Institute QM/QI policies and procedures that emphasize and promote wellness and prevention, DM of chronic illnesses, and complex service coordination.<br><br>The MCO must also submit an annual program evaluation of overall effectiveness to demonstrate improvements in the quality of clinical care and service to its members that includes the following:<br>• Goals, objectives and structure, and that result in CQI for members.<br>• Description of ongoing and completed QI activities.<br>• Trending of measures to assess performance in quality of clinical care and service.<br>• An analysis of whether or not there have been demonstrable improvements in the quality of clinical care and service.<br>• Incorporation of findings of overall effectiveness in the development of the following year's plan.<br>• Protocols for working with school age members.<br>• Member and network provider satisfaction surveys and other relevant member and family/caregiver surveys.<br>• DM protocols.<br>• Continuity and coordination of services.<br>• Tracking and trending of member and provider grievances for early identification and resolution of systems' issues and potential trends.<br>• Service coordination protocols that reflect their comprehensive needs and SP priorities, including coordination and integration of home and community-based waiver services.<br>• Provide quality oversight of ALFs. |
| 10. Other | **DM Programs**--The state requires MCOs to improve their ability to manage chronic illnesses/diseases through DM protocols in order to meet goals based on jointly established targets. The MCO must provide comprehensive DM for a minimum of 2 chronic diseases using strategies consistent with nationally recognized DM guidelines. The MCO must submit cumulative data-driven measurements from each of its DM programs with written analysis describing the effectiveness of its DM interventions as well as any modifications implemented to improve its DM performance. Annually, the MCO must submit to the state a DM plan, which includes a program description, the overall program goals, measurable objectives, targeted interventions and its methodology used to identify other diseases for potential DM programs. Annually, the MCO must also submit a quantitative evaluation of the efficacy of the prior year's DM program and demonstrate consistent improvement in the overall DM program goals. |

| Element | Description/Notes |
|---|---|
| 11. Other | **Consumer Advisory Board**--MCO's are required to have a Consumer Advisory Board according to state requirements and keep a written record of all attempts to invite and include its members in its meetings, a Board roster and minutes. The Consumer Advisory Board shall consist of an equitable representation of the MCO's members in terms of race, gender, special populations, and the state's geographic areas. |

ALF = assisted living facility
ALTSD = New Mexico Aging and Long-Term Services Department
CI = critical incident
CoLTS = Coordination of Long-Term Services
CQI = continuous quality improvement

DM = disease management
EQRO = external quality review organization
HCBS = home and community-based services
HEDIS = Health Effectiveness Data and Information Set
HSD = New Mexico Human Services Department

ISHCN = individuals with special health care needs
ISP = individualized service plan
IT = information technology
LTSS = long-term services and supports
MCO = managed care organization

PCP = primary care provider/physician
PIP = performance improvement project
QA = quality assurance
QI = quality improvement
QM = quality management

SP = service plan
TQM = total quality management

# APPENDIX K. NEW YORK MEDICAID ADVANTAGE PLUS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | New York State Department of Health (SDOH), Division of Long-Term Care |
| Program | Medicaid Advantage Plus (MAP) |
| Inception | 2006 |
| Year LTSS Added | N/A |
| Medicaid Authority | 1915(a) |
| # Enrolled | 1,875 (April 2012) |
| Group Enrolled | Elderly and physically disabled. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO must designate a compliance officer and establish a compliance committee to:<br>• Monitor the plan reporting obligations and ensure that the required reports are accurate and submitted in a timely manner.<br>• Develop written policies, procedures and standards of conduct that articulate the plan commitment to adhere to all applicable federal and state standards.<br>• Conduct appropriate staff training activities in an atmosphere of open communication.<br>• Establish provisions for internal monitoring and auditing.<br>• Have provisions for prompt responses to detected offenses with provisions for corrective action initiatives where appropriate.<br><br>The MCO must establish a review committee(s) to:<br>• Evaluate data collected pertaining to quality indicators, performance standards, and client satisfaction.<br>• Make recommendations to the board regarding the process and outcomes of the QA and performance improvement program.<br>• Provide input related to processes to evaluate ethical decision-making including end-of-life issues.<br><br>Policies and procedures of the review committee should:<br>• Define qualifications of individuals participating on the committee(s).<br>• Include a method for identifying, selecting and reviewing data and information to be used in the QA and performance improvement program.<br>• Integrate the findings of the grievance and appeals process.<br>• Define a process for recommending appropriate action to resolve problems identified as part of QA and improvement activities including:<br>- Providing feedback to appropriate staff and subcontractors for monitoring effectiveness of corrective actions taken, for reporting QA/PI findings to the board on at least an annual basis.<br>- Incorporating review of the care delivery process to include appropriate clinical professionals and paraprofessionals as well as non-clinical staff as appropriate. |

| Element | Description/Notes |
|---|---|
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>All Provider Agreements entered into by the MCO to provide services shall contain provisions specifying:<br>• That the credentials of affiliated professionals or other health care providers will be reviewed directly by the MCO or the credentialing process of the provider will be reviewed and approved by the MCO and the MCO must audit the credentialing process on an ongoing basis.<br>• How the provider shall participate in the MCO's QA, service authorization and grievance and appeals processes, and the monitoring and evaluation of the MCO's plan. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO must maintain a health information system that collects, analyzes, integrates and reports data. The system must be sufficient to provide the data necessary to comply with the requirements of the contract. The MCO must take steps to ensure that data entered into the system, particularly that received from providers is accurate and complete. The MCO must make information available to CMS and the state. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>None specified. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>The MCO is required to meet the following standards related to access, availability and continuity of service including, but not limited to:<br>• Timeliness of receipt of covered services.<br>• Quality indicators that are objective, measurable and related to the entire range of services provided by the MCO and which focus on potential clinical problem areas (high volume service, high risk diagnoses or adverse outcomes).<br><br>The methodology should assure that all care settings (e.g., day center, nursing home and in-home settings) will be included in the scope of the QA and performance improvement program. |

| Element | Description/Notes |
|---|---|
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO must have a comprehensive grievance system in place that includes a grievance process, access to a fair hearing when the MCO makes a final adverse determination about an action it has taken, an external appeal process, an action appeal process and an expedited action appeals process. The MCO must also have a complaint process and complaint appeals process. The overall system must:<br>• Establish, maintain and comply with written procedures and a comprehensive grievance system for:<br>- Services that are a Medicare only benefit;<br>- Services that are covered under both Medicare and Medicaid.<br>• The grievance system must meet requirements of state statutes.<br>• Any proposed changes to the grievance system must be approved by the state prior to implementation.<br><br>The MCO must report the following with regard to its grievance system:<br>• Quarterly summary of all complaints and action appeals.<br>• Quarterly report on the total number of complaints and action appeals that have been unresolved for more than 45 days.<br>• Quarterly summary of all grievance and appeals received.<br>• Quarterly report on the total number of grievance or appeals that have been unresolved for more than 30 days. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | Standards for access, availability and continuity of service including but not limited to:<br>• Length of time to respond to requests for referrals.<br>• Timeliness of receipt of covered services.<br>• Timeliness of implementation of care plan.<br>• Telephone consultation to assist enrollees in obtaining health information and urgent care on a 24 hour basis.<br><br>Quality indicators that are objective, measurable and related to the entire range of services provided by the MCO and focus on potential clinical problem areas (high volume service, high risk diagnoses or adverse outcomes). The methodology should assure that all care settings (e.g., day center, nursing home and in-home settings) will be included in the scope of the QA and performance improvement program. |
| 3. PIP Requirements | MCOs are required to conduct PIPs that focus on clinical and non-clinical areas to promote QI within the managed long-term care plan. At least 1 PIP each year will be selected as a priority and approved by the state. MCOs must conduct PIPs using standard measures required by CMS and to report results to CMS (if required) and the state. Standard measures may include HEDIS and HOS. MCOs are also required to conduct a CCIP relevant to its membership as directed by CMS and to submit the annual report on CCIP to CMS and the state. |
| 4. EQRO Requirements | MCOs are required to cooperate with any external quality review conducted by or at the direction of the state. |

| Element | Description/Notes |
|---|---|
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The MCO, using the patient assessment instrument specified by state, is required to evaluate all applicants to assess:<br>• Eligibility for nursing home LOC at the time of enrollment.<br>• At the time of enrollment, ability of returning to or remaining in their home and/or community without jeopardy to their health and/or safety, based upon criteria provided by the state.<br>• Expectation that applicant requires at least service and care management for at least 120 days from the effective date of enrollment. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified. |
| | **d. LTSS/acute care coordination requirements.**<br><br>Care management includes referral to and coordination of other necessary medical, and social, educational, psychosocial, financial and other services of the care plan irrespective of whether such services are covered by the plan. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | The MCO will submit reports to the state on all QAPIPs directed by CMS for the Medicare Advantage Program, including the annual report on the contractor's CCIP. Reports should be duplicative of reports submitted to CMS and separate reports for the dual eligible population are not required.<br><br>The MCO shall submit enrollee health and functional status data for each of their enrollees in the format and according to the timeframes specified by the state. The data shall consist of SAAM or any other such instrument the SDOH may request. The data shall be submitted at least semi-annually or on a more frequent basis if requested by the state. |

CCIP = Chronic Care Improvement Program
CI = critical incident
CMS = Centers for Medicare and Medicaid Services
EQRO = external quality review organization
HEDIS = Health Effectiveness Data and Information Set

HOS = Health Outcomes Survey
IT = information technology
LOC = level of care

LTSS = long-term services and supports
MAP = New York Medicaid Advantage Plus

MCO = managed care organization
PIP = performance improvement project
QA = quality assurance
QAPIP = Quality Assessment and Performance Improvement Plan
QI = quality improvement

SAAM = semi-annual assessment of member
SDOH = New York State Department of Health

# APPENDIX L. NORTH CAROLINA MENTAL HEALTH/ DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES HEALTH PLAN WAIVER

| Element | Description/Notes |
|---|---|
| State and Lead Agency | North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) |
| Program | North Carolina MH/DD/SAS Health Plan Waiver |
| Inception | 2005 |
| Year LTSS Added | Since inception. |
| Medicaid Authority | 1915(b)/(c) |
| # Enrolled | 1,426,398: Total number enrolled.<br>84,861: Using MH, DD or SAS (breakout by disability group currently not available). |
| Group Enrolled | IDD |
| Contract Date(s) | April 2012<br>Covers 2 years with the option to extend an additional year. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The LME-MCO is required to employ a full-time QM Director with at least 5 years recent QM experience and 2 years managed care experience or experience in MH, DD and SA care. The QM Director shall have a Bachelor's Degree in a Human Services Field or a Master's Degree in a human services field. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>The LME-MCO shall adopt and implement written policies and procedures governing the qualification, credentialing, re-credentialing, accreditation, and re-accreditation of its network providers, maintain records of its qualification, credentialing, and accreditation activities and make it records available to the state upon request. LME-MCO credentialing and accreditation criteria shall be consistent with state and federal rules and regulations and shall routinely monitor the licensure, certification, registration, and accreditation status of its network providers.<br><br>LME-MCOs are required to:<br>• Establish mechanisms to ensure that providers comply with the timely access requirements appointment availability and appointment wait times.<br>• Monitor providers regularly to determine compliance.<br>• Take corrective action if a provider fails to comply. |

| Element | Description/Notes |
|---|---|
| | LME-MCOs shall measure the performance of providers and conduct peer review activities such as identification of practices that do not meet plan standards, recommendation of appropriate action to correct deficiencies and monitoring of corrective action by providers.<br><br>LME-MCOs shall also measure provider performance through medical record audits, provide performance feedback to providers, including detailed discussions of clinical standards and the expectations of LME-MCO; develop and adopt clinically appropriate practice parameters and protocols/guidelines and provide LME-MCO's providers enough information about the protocols/guidelines to enable them to meet the established standards. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>LME-MCOs shall use Quality Monitoring and the CQI process to ensure that individual treatment plans are developed consistent with federal regulations and to ensure enrollee participation in the treatment planning process. LME-MCO shall manage enrollee care by performing, at a minimum, the following Care Management functions:<br>• Be available 24 hours per day, 7 days per week, to perform telephone assessments and crisis intervention.<br>• Determine which behavioral health services are medically necessary.<br>• Perform quality monitoring of the behavioral health services provided to enrollees.<br>• Coordinate and monitor behavioral health hospital and institutional admissions and discharges including discharge planning.<br>• Ensure the coordination of care with each enrollee's primary care and behavioral health providers. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>LME-MCO shall maintain a health information system that collects, analyzes, integrates, and reports data for recipients with behavioral health, DD, and SA treatment needs. One of the stated purposes of the system is for quality. Also, the LME-MCO shall collect service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The LME-MCO must submit CI reports as part of ongoing statistical reporting. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>LME-MCO shall have a grievance and appeal system in place that is compliant with federal regulations. The grievance and appeal procedures must:<br>• Be approved in writing by the state.<br>• Provide for prompt resolution of enrollee grievances and appeals.<br>• Assure the participation of individuals with the authority to require LME-MCO to take corrective action when appropriate.<br><br>In addition LME-MCOs shall:<br>• Use grievance and appeal data for QI and shall report enrollee grievances and appeals to the state by number, type, and outcome by no later than 45 calendar days after the end of each quarter of the state fiscal year.<br>• Attend state training on the enrollee appeal process.<br>• Use state standardized letters to notify recipients of their rights to appeal.<br>• Provide quarterly report on grievance and appeals. |
| | **h. Other.**<br><br>The state Medicaid, MH, IDD, SAS agencies shall jointly conduct an Annual Monitoring Review on-site at the LME-MCO. The frequency of on-site reviews may be decreased to every 2 years at the discretion of the state if it is determined that other on-site review activities required by CMS are sufficient to assure the effective operation of LME-MCO and compliance with state and federal requirements. The Review includes the LME-MCO's compliance the requirements of this contract and with state and federal Medicaid requirements.<br><br>An IMT meets at least quarterly to review Performance Indicators, reports and data, and timeliness of submission of reports. The Medicaid Agency leads the IMT, in collaboration with DMH/DD/SAS. At a minimum, the IMT shall include representatives from the following sections and offices:<br><br>• Medicaid:<br>- Finance Management;<br>- Behavioral Health, Clinical Policies and Programs;<br>- QEHO;<br>- Waiver Development;<br>- Budget Management;<br>- Program integrity;<br>- IT. |

| Element | Description/Notes |
|---|---|
| | • DMH/DD/SAS:<br>  - Best Practice;<br>  - Financial Operations;<br>  - LME System Performance Team;<br>  - QM;<br>  - Accountability;<br>  - Advocacy and Customer Service;<br>  - IT.<br>• LME-MCO:<br>  - Management;<br>  - Finance;<br>  - Information System;<br>  - Operations (Access, Network, Waiver Implementation);<br>  - Quality.<br>• State:<br>  - Office of the Controller;<br>  - Office of Budget and Analysis. |
| 2. LTSS Performance Measures Requirements | Performance measures for LTSS recipients include the following measures specific to individuals with a primary diagnosis of IDD:<br>• Health and safety.<br>• Choice.<br>• Quality of the SP.<br>• Provider remediation, compliance, standards, enrollment and capacity.<br>• LOC process and instrument.<br>• Slot transfer and tracking.<br><br>The following measures are specific to individuals with a primary diagnosis of MI or SA.<br><br>Effectiveness of care measures:<br>• Follow-up after hospitalization for mental illness (HEDIS).<br>• 30 day readmission rates for MH hospitalization.<br>• 30 day readmission rates for SA hospitalization.<br>• Ambulatory follow-up within 7 and 30 calendar days of hospital discharge for SA therapy.<br>• Ambulatory follow-up within 7 and 30 calendar days of discharge for MH.<br><br>Access and Availability:<br>• Initiation and engagement of alcohol and other drug dependence treatment (HEDIS).<br>• Call answer timeliness (HEDIS).<br>• Call abandonment (HEDIS).<br>• Number and percent of requests for authorization that were denied by LME-MCO.<br>• Number and percent of services rendered by an out of network provider. |

| Element | Description/Notes |
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| | Use of Services:<br>• MH Utilization--Inpatient discharges and average length of stay (HEDIS).<br>• MH Utilization--Percentage of members receiving inpatient, day/night care, ambulatory and other support services (HEDIS).<br>• Chemical Dependence Utilization--Inpatient discharges and average length of stay (HEDIS).<br>• Chemical Dependency Utilization--Percentage of members of receiving inpatient, day/night care, ambulatory and other support services.<br>• Integrated Care--For adults, reports the percentage of enrollees who had an ambulatory or preventative care visit during the measurement year. For children and adolescents, reports the percentage that had a visit with a PCP.<br><br>LME-MCOs are required to implement a total of 3 PIPs over the 2 years of the contract. During year 1, the LME-MCO shall implement 2 PIPS, 1 clinical and 1 non-clinical.<br><br>Appropriate topics for PIPs include:<br>• Primary, secondary and/or tertiary prevention of acute mental illness conditions.<br>• Primary, secondary and/or tertiary prevention of chronic mental illness conditions.<br>• Care of acute mental illness conditions.<br>• Recovery/outcome measures.<br>• Care of chronic mental illness conditions.<br>• High volume services.<br>• High risk services.<br>• Continuity and coordination of care.<br>• Availability, accessibility, and cultural competency of services.<br>• Quality of provider/patient encounters.<br>• Appeals and grievances. |
| 3. PIP Requirements | The state will contract with an EQRO to conduct an annual independent external quality review that includes the following:<br>• Determining LME-MCO compliance with federal Medicaid managed care regulations.<br>• Validation of performance measures produced by LME-MCOs.<br>• Validation of PIPs undertaken by LME-MCOs.<br><br>CMS-published protocols shall be utilized by the EQRO. In addition, based on the availability of encounter data, the EQRO shall conduct encounter data validation per the CMS protocols. The LME-MCO is required to address the EQRO findings. |
| 4. EQRO Requirements | The state contracts with an EQRO to conduct an annual independent external quality review. The EQRO conducts 3 mandatory activities during these reviews: (1) determining PIHP compliance with federal Medicaid managed care regulations; (2) validation of performance measures produced by the PIHP; and (3) validation of PIPs undertaken by the PIHP. In addition, the EQRO conducts encounter data validation based on the availability of encounter data. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The LME-MCO is required to use the LOC tool for the 1915(c) waiver. |

| Element | Description/Notes |
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| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified. |
| | **d. LTSS/acute care coordination requirements.**<br><br>Care coordination shall be coordinated with the physical health Medicaid providers (Community Care--CCNC network). The LME-MCO is to use the 4 quadrant method to determine if behavioral health or physical health needs are predominant.<br>• If behavioral health needs are predominant, the LME-MCO is responsible for care coordination.<br>• If physical health needs are more pressing then CCNC is to provide care coordination.<br><br>The LME-MCO shall ensure the coordination of care with each enrollee's PCP/Health Home. The LME-MCO shall encourage, support and facilitate communication between PCPs and behavioral health providers regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons determined to have need. (The LME-MCO shall conduct at least 1 coordination meeting per month).<br><br>The LME-MCO shall also ensure acute care coordination through the following mechanisms:<br>• LME-MCOs have the responsibility to provide feedback to the referring source on all referrals.<br>• LME-MCOs shall conduct at least 1 meeting per month to facilitate communication.<br>• LME-MCOs shall provide follow-up activities to:<br>- High risk enrollees who do not appear for scheduled appointments;<br>- Enrollees for whom a crisis service has been provided as the first service to facilitate engagement with ongoing care;<br>- Individuals discharged from 24 hour care.<br><br>LME-MCOs shall ensure that each enrollee's privacy is protected in accordance with state and federal law. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified.*<br><br>*Supports Intensity Scale and Supports Needs are referenced in the contract. |
| 6. Ombudsman (Function) Requirements | None specified. |

| Element | Description/Notes |
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| 7. Quality-Related Financial Incentives | The LME-MCO shall conduct a patient satisfaction survey annually using a survey instrument approved by the state. The LME-MCO shall be required to use some statewide standardized questions on each survey. The LME-MCO must have the patient satisfaction survey created and administered by an outside vendor. The survey shall utilize the sampling and format defined by the NCQA. The results of the survey must be submitted to the state. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | LME-MCOs are required to report Medicaid 1915(c) HCBS waiver performance measures. |
| 9. LTSS Quality Review | LME-MCOs are required to report Medicaid 1915(c) HCBS waiver performance measures. |

CCNC = Community Care of North Carolina
CI = critical incident
CMS = Centers for Medicare and Medicaid Services
CQI = continuous quality improvement
DD = developmental disability

DHHS = North Carolina Department of Health and Human Services
DMA = North Carolina Division of Medical Assistance
DMH/DD/SAS = North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
EQRO = external quality review organization
HCBS = home and community-based services

HEDIS = Health Effectiveness Data and Information Set
IDD = intellectual and developmental disabilities
IMT = intra-departmental monitoring team
IT = information technology
LME = local management entity

LTSS = long-term services and supports
MCO = managed care organization
MH = mental health
MI = mentally ill
NCQA = National Committee on Quality Assurance

PCP = primary care provider/physician
PIHP = Pre-paid Inpatient Health Plan
PIP = performance improvement project
QEHO = quality, evaluation, and health outcomes
QI = quality improvement

QM = quality management
SA = substance abuse
SAS = substance abuse services
SP = service plan

# APPENDIX M. PENNSYLVANIA ADULT COMMUNITY AUTISM PROGRAM

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Pennsylvania Office of Developmental Programs, Bureau of Autism Services |
| Program | Adult Community Autism Program (ACAP) |
| Inception | 2009 |
| Year LTSS Added | 2009 |
| Medicaid Authority | 1915(a) |
| # Enrolled | 110 |
| Group Enrolled | Adults with autism. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO is required to establish a Plan Advisory Committee that includes the Medical Director, a Behavioral Health Practitioner, a parent of an adult with autism, providers representing the scope of services provided under the Plan, and representatives from the religious, law, and ethics communities.<br><br>The Plan Advisory Committee will report to and advise the governing body on matters related to the complaint and grievance processes, QM, utilization review processes, and ethics.<br><br>The MCO shall establish, maintain, and provide support to a QM and Utilization Review Committee. The Committee shall provide guidance and assistance to support the MCO in carrying out the following responsibilities:<br>• Developing mechanisms for collecting and evaluating information, identifying problems, formulating recommendations, disseminating information.<br>• Implementing corrective actions and evaluating the effectiveness of action taken.<br>• Reviewing annually and making recommendations concerning the formulation, revision or implementation of the policies governing the scope of services offered, practice guidelines, medical supervision, ISPs, crisis intervention care, clinical records, personnel qualifications and program evaluation.<br>• Providing technical advice regarding professional questions and individual service problems.<br>• Participating in program evaluation including annual evaluation of the MCO's performance.<br>• Assisting in maintaining liaison with professional groups and health providers in the community.<br>• Participating in the development and ongoing review of written policies, procedures, and standards of patient care and QM.<br>• Reviewing the adequacy and effectiveness of QM and utilization activities on a quarterly basis.<br>• Developing mechanisms for evaluating responsiveness of the complaint and grievance processes and for collecting and analyzing information about voluntary disenrollments. |

| Element | Description/Notes |
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| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>When the MCO or the state identifies deficiencies or areas for improvement in a provider's performance, the MCO and provider must take corrective action to ensure that the provider removes the deficiencies and improves performance.<br><br>The MCO is required to:<br>• Establish ongoing mechanisms to monitor provider compliance with the state's standard for timely access to care and services as specified.<br>• Monitor the performance of its providers on an ongoing basis, conducting formal review of each provider at least annually and if any deficiencies or areas of improvement are identified, take corrective action or require the provider to take corrective action to detect both under utilization and over utilization of services and to assess the quality and appropriateness of care furnished to all participants. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO is required to purchase all compatible computer software and required licenses for the MCO's and the state's use as may be necessary to allow for electronic communication and transfer of information between the MCO and the state. The software must allow the MCO to collect, analyze, integrate, and report data. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The MCO must ensure that the MCO and each provider responds, reports, and follows up on CIs as specified by the state.<br><br>The MCO is required to develop Seclusion and Restraint policies and procedures and ensure that staff and providers receive training on these policies and the appropriate use of these restraints identified in the approved behavioral support plan. MCOs are required to file an incident report any time a Restraint is used. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>The MCO is required to ensure that authorized services are delivered timely and consistent with the needs of the participant. The MCO must have a mechanism to detect both under utilization and over utilization of services and to assess the quality and appropriateness of care furnished to all participants. |

| Element | Description/Notes |
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| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO shall develop complaint, grievance, and state fair hearing procedures that must be approved by the state before implementation. The MCO must inform each participant verbally and in the Participant Handbook of the Participant's right to file a complaint or grievance, the requirements and timeframes for filing a complaint or grievance, the availability of assistance in the filing process, the toll-free numbers that the participant can use to file a complaint or grievance, and the participant's right to request the state's fair hearing. The MCO must inform the provider of the right of each participant to file a complaint or grievance. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | Performance Measures include:<br>• Fewer episodes of :<br>- Law enforcement involvement;<br>- Psychiatric inpatient and ER hospitalizations;<br>- MH crisis interventions.<br>• Increase in percentages of participants with jobs or volunteer opportunities.<br>• Participant satisfaction and quality of life indicators.<br>• Percentages of:<br>- Complaints received and resolved;<br>- Grievances received and resolved. |
| 3. PIP Requirements | If deficiencies are identified by the MCO or the state, the MCO is required to develop a corrective action plan to improve performance. |
| 4. EQRO Requirements | The MCO is required to comply with requests from the state for submission of data required to complete an annual external independent review of the quality outcomes, timeline and access to authorized services. The MCO is also required to cooperate with the state/authorized representatives in the state's monitoring of the MCO and provider compliance with the contract requirements and the provider's performance as it relates to participant outcomes and consistency of quality indicators. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The MCO is required to complete an assessment annually designated by the state for each participant and shall transmit the results of the assessments to the state in an electronic format. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>The MCO is responsible for developing an initial support plan within 14 days of being notified by the state that an applicant is eligible for enrollment. The plan must be reviewed at least every 3 months and after each episode that triggers implementation of the crisis intervention plan or the use of a restraint and must be reassessed and updated at least annually. Monitoring and annual reassessments must address the participant's progress toward more inclusive and less restrictive services than were provided the previous year. |

| Element | Description/Notes |
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| | **d. LTSS/acute care coordination requirements.**<br><br>The MCO is required to ensure that every participant has an assigned PCP. The MCO is required to assign a team to each participant, which is responsible for assessment, service planning, care delivery and managing delivery of services, quality of services, and continuity of care. The team shall include the participant, participant's guardian if the participant has a guardian, and his or her family consistent with the participant's or guardian's wishes, a behavioral health specialist, and supports coordinator.<br><br>The MCO is required to ensure that the authorized services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.<br><br>The MCO shall establish practice guidelines to govern the authorization and delivery of services which are:<br>• Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.<br>• Adopted in consultation with contracting health care professionals.<br>• Reviewed and updated periodically as appropriate.<br><br>Practice guidelines must be approved by the state before being implemented. Guidelines must be shared with all affected providers and upon request, with participants and applicants. |
| | **e. Risk assessment and mitigation requirements.**<br><br>The MCO s required to develop a crisis intervention plan to plan for a crisis event to protect the partitioned from hurting himself/herself or others. The MCO will reassess the plan to avoid a crisis event in the future. A description of how the effectiveness of the plan and its implementation in supporting the participant will be monitored and evaluated on a regular basis and after each crisis event. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | The MCO is required to regularly evaluate participants' satisfaction with services and shall facilitate implementation of such consumer satisfaction surveys as the state determines are necessary in order to evaluate services provided. |

| Element | Description/Notes |
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| 9. LTSS Quality Review | The MCO is required to submit a written report of QM activities including standard measures required by the state on an annual basis which describes topics reviewed, method of review, recommendations for improvement, and evaluation of corrective actions implemented.<br><br>The MCO is required to meet with the state on a semi-annual basis to review the MCO's performance, the development of specific quality goals, and establishment of performance measurement criteria. The MCO must submit the reports required by the state 2 weeks before it meets with the state.<br><br>The MCO is required to submit quarterly reports that include the following information:<br>• Number of participant deaths.<br>• Number of complaints received and resolved.<br>• Number of grievances received and resolved.<br>• Services furnished to participants. |
| 10. Other | The MCO is required to maintain an after-hours call-in system to provide access, 24 hours per day, 7 days per week to covered services when medically necessary. |

ACAP = Adult Community Autism Program
CI = critical incident
EQRO = external quality review organization
ER = emergency room
IT = information technology

LTSS = long-term services and supports
MCO = managed care organization
MH = mental health
PCP = primary care provider/physician
PIP = performance improvement project

QM = quality management

# APPENDIX N. TENNESSEE TENNCARE CHOICES

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Tennessee Department of Finance and Administration, Bureau of TennCare, Division of Long-term Services and Supports |
| Program | TennCare CHOICES in Long-Term Services and Supports |
| Inception | 1993 |
| Year LTSS Added | 2010 |
| Medicaid Authority | 1115 Demonstration Waiver |
| # Enrolled | 31,890 (September 1, 2013)<br>Subset of members using LTSS: All CHOICES members use LTSS; 1.2 million enrolled in the broader TennCare managed care program. |
| Group Enrolled | Persons of all ages residing in nursing homes.<br>Adults 21+ with a PD/LTSS needs.<br>Seniors 65+ with LTSS needs. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCOs are required to have a QM/QI program that is accountable to the MCO's board of directors and executive management team, have a QM/QI committee that oversees the QM/QI functions and a staff person responsible for all QI/QM activities. The QM/QI committees are required to include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). The QI/QM committee is required to notify the CMO of TennCare of meetings in a timely fashion and to the extent allowed by law, the CMO of TennCare, or his/her designee, may attend the QM/QI committee meetings at his/her option. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations. MCO must have a senior executive responsible for overseeing all subcontractor activities and a staff person responsible for all UM activities, including overseeing prior authorizations. MCOs are to be responsible for confirming the provider's capacity and commitment to initiate services. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>The MCO will have a full-time staff person dedicated to the TennCare CHOICES program who is a RN and has at least 3 years' experience providing care coordination to persons receiving long-term care services and an additional 2 years' work experience in managed and/or long-term care. This person will oversee and be responsible for all care coordination activities.<br><br>Quality of care activities will be monitored through information obtained in a quarterly CHOICES Care Coordination Report and through activities performed by the Quality Oversight Division of TennCare. |

| Element | Description/Notes |
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| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs are required to have Information management processes and Information Systems that enable it to meet TennCare and federal reporting requirements and other Agreement requirements and that are in compliance with this Agreement and all applicable state and federal laws, rules and regulations including HIPAA. The MCO's Systems is required to possess capacity sufficient to handle the workload projected for the start date of operations and will be scalable and flexible so they can be adapted as-needed, within negotiated timeframes, in response to changes in agreement requirements, increases in enrollment estimates, etc. MCOs and TennCare are required to establish an information systems workgroup/committee to coordinate activities and develop cohesive systems strategies. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>Process:<br>• MCOs develop and implement an abuse/neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of members; a plan for educating and training providers, subcontractors, care coordinators, and other MCO staff regarding the protocols; and a plan for training members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.<br>• MCOs are required to develop and implement a CI reporting and management system for incidents that occur in a home and community-based long-term care service delivery settings.<br>• MCOs are required to identify and track CIs and will review and analyze CIs to identify and address potential and actual quality of care and/or health and safety issues. The MCO will regularly review the number and types of incidents and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.<br>• MCOs require its staff and contract CHOICES HCBS providers to report, respond to, and document CIs as specified by the state.<br><br>Reports: MCOs submit:<br>• Quarterly CHOICES HCBS CIs Report (MFP participants will be identified).<br>• Quarterly Behavioral Health Adverse Occurrences Report that provides information, by month regarding specified measures, which will include the number of adverse occurrences, date of occurrence, type of adverse occurrence, location, provider name; and action taken by facility/provider. |

| Element | Description/Notes |
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| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>When MCOs begin initiation of the member's POC, the member's care coordinator/care coordination team is required to monitor to ensure that services have been initiated and continue to be provided as authorized. This includes ongoing monitoring via EVV to ensure that services are provided in accordance with the member's POC, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs.<br><br>MCOs are required to conduct monthly monitoring regarding missed and late visits. State reviews Late and Missed Visits reports submitted by the MCO to determine the MCO's performance. The state may validate the report and may conduct a more in-depth review and/or request additional information and may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve MCO performance. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>Members have the right to file appeals regarding adverse actions taken by the MCO to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the MCO which impair the quality, timeliness, or availability of such benefits.<br><br>Complaint means a written or verbal expression of dissatisfaction about an action taken by the MCO or service provider other than those that meet the definition of an adverse action such as quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee.<br><br>MCOs will devote a portion of its regularly scheduled QM/QI committee meetings to the review of member complaints and appeals that have been received.<br><br>MCOs will ensure that punitive action is not taken against a provider or worker who files an appeal on behalf of a member.<br><br>MCOs submit a quarterly Member Complaints Report that includes information regarding the number of complaints received by type, and by member group, and the number and percent of complaints for which the MCO met/did not meet the specified timeframe for resolution. The report also includes identification of any trends regarding complaints (e.g., the type or number of complaints) and any action steps to address these trends, including QI activities.<br><br>MCOs submit a quarterly Provider Complaints Report that provides information on the number and type of provider complaints received, either in writing or by phone, by type of provider, and the disposition/resolution of those complaints. |

| Element | Description/Notes |
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| | **h. Other.**<br><br>**State Annual Monitoring**<br>• State/designee (or CMS) annually monitors the operation of MCO for compliance with the provisions of contract and applicable federal and state laws and regulations.<br>• Monitoring activities will include inspection of MCO's facilities, auditing and/or review of all records developed under the Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement.<br>• State emphasizes case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purpose.<br>• State prepares a report of its findings and recommendations and will require MCOs to develop corrective action plans as appropriate. |
| | **i. Other.**<br><br>**Staffing and Background Checks**<br>• MCO is required to have sufficient full-time clinical and support staff to conduct daily business including administration, accounting and finance, fraud and abuse, UM including prior authorizations, MCO case management, DM, care coordination, QM/QI, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.<br>• MCO is responsible for ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of MCO, are legally authorized to render services under applicable state law.<br>• Fiscal Intermediary is responsible for ensuring that consumer-directed workers are qualified to provide services in accordance with state requirements.<br>• MCO is responsible for conducting background checks in accordance with state law and policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the MCO conducts background checks in accordance with state law and policy. Background checks will include a check of the state's Abuse Registry, Felony Offender Registry, National and State Sexual Offender Registry, and LEIE. The FI will be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. |
| 2. LTSS Performance Measures Requirements | Not specified in contract. However, contract specifies multiple reports related to quality. See Element #9 below. |
| 3. PIP Requirements | MCOs are required to perform at least 2 clinical PIPs with at least 1 PIP in the area of behavioral health. The behavioral health PIP is required to be relevant to 1 of the behavioral health DM programs for bipolar disorder, major depression, or schizophrenia. MCOs are required to submit an annual report on PIPs. |
| 4. EQRO Requirements | MCOs are required to cooperate with EQRO which will conduct a periodic and/or an annual independent review of the MCO.<br><br>MCO QI/QM committee meeting minutes are to be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review. |

| Element | Description/Notes |
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| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>MCOs may employ a screening process, using state-specified tools and protocols.<br><br>MCO care coordinators conduct any needs assessment deemed necessary by the MCO using a state-approved tool. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>Although care coordinator ratios requirements are not stipulated, MCOs submit a monthly caseload and staffing ratio report that reflects the weighted care coordinator-to-member staffing ratios and care coordinator caseloads. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>Requirements for frequency of monitoring are dependent upon the level or group the member is in.<br><br>Members in CHOICES Group 1 (who are residents of a NF) and who are 21 years of age and older are to receive a face-to-face visit from their care coordinator at least twice a year. Members in CHOICES Group 1 (who are residents of a NF) who are under the age of 21 are to receive a face-to-face visit from their care coordinator at least quarterly.<br><br>Members in CHOICES Group 2 (age 65+ or 21+ with disability meeting NF LOC) are to be contacted by their care coordinator at least monthly either in person or by telephone. These members are to be visited in their residence face-to-face by their care coordinator at least quarterly.<br><br>Members in CHOICES Group 3 (age 65+ or 21+ with disability who do not meet NF LOC and in the absence of HCBS are at risk for NF care) are to be contacted by their care coordinator at least quarterly either in-person or by telephone. These members are to be visited in their residence face-to-face by their care coordinator at least semi-annually. |
| | **d. LTSS/acute care coordination requirements.**<br><br>MCOs are required to use care coordination as the continuous process of:<br>• Assessing a member's physical, behavioral, functional, and psychosocial needs.<br>• Identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs.<br>• Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence.<br>• Facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement. |

| Element | Description/Notes |
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| | **e. Risk assessment and mitigation requirements.**<br><br>MCOs conduct a risk assessment using state-specified tool and protocol and develop, as applicable, a risk agreement to be signed by the applicant or his/her representative which will include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk. MCO care coordinators review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign and date any revised risk agreement. |
| 6. Ombudsman (Function) Requirements | Long-Term Care Ombudsman Program--A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the state. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the TCAD.<br><br>A consumer advocate for members will be responsible for internal representation of members' interests including input into planning and delivery of long-term care services, QM/QI activities, program monitoring and evaluation, and member, family, and provider education. |
| 7. Quality-Related Financial Incentives | Financial incentives will be paid to the MCO based on activities performed as part of the MFP Rebalancing Demonstration in accordance with the following:<br>• Upon successful transition to the community of each MFP demonstration participant up to and including the MCO's established benchmark for the calendar year--a one-time payment of $1,000.<br>• If a member has been enrolled in more than 1 MCO during the 90-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.<br>Upon successful transition to the community of each MFP demonstration participant that exceeds the MCO's established benchmark for the calendar year--a one-time payment of $2,000.<br>• If a member has been enrolled in more than 1 MCO during the 90-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.<br>• Upon each MFP demonstration participant's completion of community living for the full 365-day demonstration participation period without readmission to a NF (excluding short-term SNF stays solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare), a one-time payment of $5,000.<br>• If a member has been enrolled in more than 1 MCO during the 365-day participation period in MFP, a pro-rated portion of the incentive payment shall be awarded to each MCO based on the number of days the member was enrolled in each plan. Only days included in the 365-day participation period shall be counted and not any days during which MFP participation was suspended during an inpatient facility stay. |

| Element | Description/Notes |
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| | • Additionally, payments are provided dependent upon the MCOs ability to achieve MFP Program Benchmarks, which address:<br>- Number of individuals in each target group in successfully transitioning from an inpatient facility to a qualified residence.<br>- Percentage of Medicaid spending for qualified home and community-based long-term care services.<br>- Number and percentage of individuals who are elderly and adults with PD receiving Medicaid-reimbursed long-term care services in home and community-based (versus institutional) settings.<br>- Number of unduplicated licensed CBRAs contracted with MCOs statewide to provide HCBS in the CHOICES program during each year of the demonstration. Number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | MCOs are required to review all reports submitted to the state to:<br>• Identify instances and/or patterns of non-compliance.<br>• Determine and analyze the reasons for non-compliance.<br>• Identify and implement actions to correct instances of non-compliance<br>• Address patterns of non-compliance.<br>• Identify and implement QI activities to improve performance and ensure compliance going forward.<br><br>The MCO will submit additional reports as follows:<br>• Quality of care activities will be monitored through information obtained in a quarterly CHOICES Care Coordination Report and through activities performed by the Quality Oversight Division of TennCare.<br>• Quarterly 24/7 Nurse Triage Line Report that lists the total calls received by the 24/7 nurse triage line, including the number of calls from CHOICES members, including the ultimate disposition of the call.<br>• Quarterly CHOICES Care Coordination Report, in a format specified by TennCare that includes, information on care coordination staffing, enrollment and care coordination contacts, ongoing assessment, care planning and service initiation, and self-directed health care task.<br>• MCO will identify and immediately respond to problems and issues, service gaps, and complaints or concerns regarding the quality of care rendered by providers, workers, or care coordination staff.<br>• Member services and provider services phone line reports.<br><br>MCOS are also required to submit the following LTSS-related reports including:<br>• Status of transitioning CHOICES member report.<br>• CHOICES NF diversion activities report.<br>• CHOICES NF-to-community transition report.<br>• CHOICES HCBS late and missed visits report.<br>• CHOICES consumer direction of eligible CHOICES HCBS report.<br>• CHOICES care coordination report.<br>• Monthly CHOICES caseload and staffing ratio report.<br>• Quarterly MFP participants report. |

| Element | Description/Notes |
|---|---|
| 10. Other | Program Evaluation (Satisfaction and Effectiveness) which will include the following:<br>• Rate of in-patient admissions and re-admissions of CM members.<br>• Rate of ER utilization by CM members.<br>• Percent of member satisfaction specific to CM.<br>• Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and to maximize community placement strategies. |

ADA = Americans with Disabilities Act
CI = critical incident
CMO = Chief Medical Officer
CMS = Centers for Medicare and Medicaid Services
DM = disease management

EQRO = external quality review organization
ER = emergency room
EVV = electronic visit verification
HCBS = home and community-based services
HIPAA = Health Insurance Portability and Accountability Act

IT = information technology
LEIE = List of Excluded Individuals/Entities
LOC = level of care
LTSS = long-term services and supports
MCO = managed care organization

MFP = Money-Follows-the-Person
NCQA = National Committee on Quality Assurance
NF = nursing facility
PD = physical disability
PIP = performance improvement project

POC = plan of care
QI = quality improvement
QM = quality management
RN = registered nurse
SNF = skilled nursing facility

TCAD = Tennessee Commission on Aging and Disability
UM = utilization management

# APPENDIX O. TEXAS STAR+PLUS

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Texas Health and Human Services Commission (HHSC) |
| Program | STAR+PLUS |
| Inception | 1998 |
| Year LTSS Added | 1998 |
| Medicaid Authority | 1915(b)/(c) waivers--now 1115 |
| # Enrolled | 400,790 (June 2012)<br>Subset using LTSS is 71,239 |
| Group Enrolled | Medicaid beneficiaries who receive SSI and/or qualify for certain waiver services.<br>Includes dual eligibles. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>The MCO must designate key executive staff with responsibility for QI. If there is any change in this key position the MCO must notify the state within 15 business days. Additionally, the MCO must designate a senior executive responsible for the QI program and the MCO Medical Director must have substantial involvement in program activities. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>**Provider Credentialing**--MCOs must review, approve, and periodically recertify the credentials of all participating licensed providers who participate in the MCO's provider network. Credentialing may be subcontracted if the delegated credentialing is maintained in accordance with the NCQA delegated credentialing requirements and any comparable requirements defined by the state. Credentialing and re-credentialing processes must be consistent with recognized MCO industry standards, including NCQA standards and federal regulations. The initial credentialing process, including application and verification of information must be completed before the effective date of the initial contract with the provider. The re-credentialing process must occur at least every 3 years.<br><br>**Provider Profiling**--MCOs must conduct PCP and other provider profiling activities at least annually. As part of its quality program, the MCO must describe the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers. Provider profiling activities must include, but not be limited to:<br>• Developing PCP and provider-specific reports that include a multi-dimensional assessment of a PCP or provider's performance using clinical, administrative, and member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population.<br>• Establishing PCP, provider, group, service area or regional benchmarks for areas profiled, where applicable.<br>• Providing feedback to individual PCPs and providers regarding the results of their performance and the overall performance of the provider network. |

| Element | Description/Notes |
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| | **Network Adequacy**--MCOs are required to systematically and regularly verify that covered services furnished by providers are available and accessible to members in compliance with established appointment wait time standards and within established geographical standard for covered services furnished by PCPs. The MCO must enforce access and other network standards required by the contract and take appropriate action with providers whose performance is determined by the MCO to be out-of-compliance. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>MCOs are required to monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary service coordination functions for the members in a timely manner. |
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs must maintain a MIS that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. This also extends to MIS subcontractors. The MCO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the various operational and administrative areas, including QI. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>None specified. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>None specified. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>The MCO must develop, implement and maintain a system for tracking, resolving, and reporting member complaints and appeals. The MCO must ensure that member complaints and appeals are resolved within 30 calendar days after receipt. If 98% are not resolved in a timely manner, the MCO can be subject to financial penalties. The MCO appeals process must comply with federal regulations.<br><br>The MCO must also provide designated Member Advocates to assist members in understanding and using the appeal process. The MCO's Member Advocates must assist members in writing or filing an appeal and monitoring the appeal through the MCO's appeal process until the issue is resolved. |
| | **h. Other.**<br><br>The state may conduct performance profiling of MCOs and recognize MCOs that attain superior performance and/or improvement by publicizing their achievements. Conversely, the state may publicize poor MCO performance. This can include posting reports on the Internet. |

| Element | Description/Notes |
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| 2. LTSS Performance Measures Requirements | Annual performance measures include:<br>• Percent members with good access to service coordination.<br>• Percent increase in members that receive personal attendant and/or respite services through the consumer-directed services delivery model.<br>• Number of members entering NF.<br>• Number of waiver clients returning to community services. |
| 3. PIP Requirements | Each year, the state establishes 2 overarching goals and negotiates a third goal suggested by the MCO for the following calendar year. The MCO must identify and propose 3 annual PIPs relating to the overarching goals for the following calendar year. At least 1 PIP must be related to an overarching goal established by the state. Once finalized, the overarching goals and PIPs are incorporated into the contract. If the state and the MCO cannot agree on the overarching goal or PIPs, the state will unilaterally select them. PIPs will follow CMS protocol. The purpose of health care quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for such projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. |
| 4. EQRO Requirements | MCOs are required to collaborate with state's EQRO to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to members and to identify opportunities for MCO improvement. To facilitate this process, MCOs are required to supply claims data to the EQRO in a format identified by the state in consultation with MCOs, and will supply medical records for focused clinical reviews conducted by the EQRO.<br><br>MCOs must also work collaboratively with the state and the EQRO to annually measure selected HEDIS measures that require chart reviews. During the first year of operations, the state anticipates that the selected measures will include, at a minimum, well-child visits and immunizations, appropriate use of asthma medications, measures related to members with diabetes, and control of high blood pressure. Additionally, the state or the EQRO will evaluate the MCO's DM program. The state may also request that the MCO submit encounter data file to the EQRO in the format provided in the Uniform Managed Care Manual. The EQRO has an additional role in collection and calculation of HEDIS, CAHPS, and other performance measures. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>MCOs are required to use the state's Task/Hour Guide to assess a member's need for Personal Assistance Service. For members and applicants seeking or needing HCBS Waiver services, the MCO must use the state's Community Medical Necessity and LOC Assessment Instrument. The MCOs will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **d. LTSS/acute care coordination requirements.**<br><br>The MCO must ensure that each member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including Acute Care, long-term care and Behavioral Health Services. The Service Coordinator must work with the member's PCP to coordinate all Covered Services and any applicable non-capitated services. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |
| 6. Ombudsman (Function) Requirements | The MCO is required to provide Member Advocates to assist members. Member Advocates must be physically located within the service area and must inform members of their rights and responsibilities, the complaints and appeals process and the array of services that are available to them. Member Advocates must also assist members in writing complaints and are responsible for monitoring the complaint. Member Advocates are responsible for making recommendations to MCO management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for helping or referring members to community resources available to meet member needs that are not available from the MCO as covered services. |
| 7. Quality-Related Financial Incentives | The state has established the following quality-related financial incentives:<br>• 5% risk--The state will place each MCO at risk for 5% of the Capitation Payment(s). If the MCO meets the performance expectations they will receive up to 100% of the risk reserve.<br>• Quality Challenge Award--If 1 or more MCOs are unable to earn the full amount of the performance-based at risk portion of the Capitation Rate, the state will reallocate all or part of the funds through the MCOs Program's Quality Challenge Award. The state will use these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. The state will determine the number of MCOs that will receive these funds annually based on the amount of the funds to be reallocated.<br>• Additionally, there are programs based on inpatient and nursing home utilization. These MCOs must achieve a 22% reduction in projected FFS Hospital Inpatient Stay costs, for the Medicaid-only population, through the implementation of the STAR+PLUS model. MCOs achieving savings beyond 22% will be eligible for the STAR+PLUS Shared Savings Award and will be at risk for savings less than 22%.<br>• NF Utilization Dis-incentive--The state will compare the annual rate of nursing home admissions for enrollees to determine if there is a statistically significant increase in admissions. Those admitted and discharged within 120 days are excluded.<br>• Additional Incentives and Dis-incentives--The state will evaluate all performance-based incentives and dis-incentive methodologies annually and in consultation with the MCOs. The state may then modify the methodologies as-needed in an effort to motivate, recognize, and reward MCO for performance. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |

| Element | Description/Notes |
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| 9. LTSS Quality Review | The MCO must file quarterly LTSS utilization reports. |

CAHPS = Consumer Assessment Health Care Providers and Systems
CI = critical incident
DM = disease management
EQRO = external quality review organization
FFS = fee-for-service

HCBS = home and community-based services
HEDIS = Health Effectiveness Data and Information Set
HHSC = Texas Health and Human Services Commission
IT = information technology
LOC = level of care

LTSS = long-term services and supports
MCO = managed care organization
MIS = Management Information System
NCQA = National Committee on Quality Assurance
NF = nursing facility

PCP = primary care provider/physician
PIP = performance improvement project
QI = quality improvement
SSI = Supplemental Security Income

# APPENDIX P. WASHINGTON MEDICAID INTEGRATION PARTNERSHIP

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Washington Department of Social and Health Services (DSHS) |
| Program | Washington Medicaid Integration Partnership (WMIP) |
| Inception | 2005 |
| Year LTSS Added | 2006 |
| Medicaid Authority | 1932(a) |
| # Enrolled | 4,834 (May 2012) |
| Group Enrolled | Adults 21-64 with SSI or SSI-related Medicaid<br>Adults 65+ |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCOs are required to have a QI Committee that oversees the quality functions of the MCO. The committee is comprised of:<br>• A MH professional with substantial involvement in the implementation of mental health care aspects of the QAPIP.<br>• A chemical dependency professional with substantial involvement in the implementation of chemical dependency health care aspects of the QAPIP.<br>• A geriatric specialist with substantial involvement in the implementation of the long-term care aspects of the QAPIP. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>The MCO's policies and procedures related to the credentialing and re-credentialing of providers must comply with federal regulations and shall ensure compliance with the following requirements:<br>• The MCO's medical director or other designated physician's shall have direct responsibility and participation in the credentialing process.<br>• The MCO must have a designated Credentialing Committee to oversee credentialing process.<br>• Identification of the type of providers that are credentialed and re-credentialed.<br>• Verification sources used to make credentialing decisions, including any evidence of provider sanction.<br>• Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law.<br><br>The MCO must also have a process for re-credentialing providers at least every 36 months through information verified from primary sources. The MCO must also have a system for monitoring sanctions or limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on state-defined methods or criteria. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>The MCO shall maintain, and shall require subcontractors to maintain, a health information system that complies with federal requirements and provides the information necessary to meet the MCOs contractual obligations.<br><br>The MCO must have in place mechanisms to verify the health information received from subcontractors by having the ability to:<br>• Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility.<br>• Ensure data received from providers is accurate and complete by:<br>- Verifying the accuracy and timeliness of reported data;<br>- Screening the data for completeness, logic, and consistency;<br>- Collecting service information on standardized formats to the extent feasible and appropriate.<br><br>The MCO shall make all collected data available to the state and CMS upon request. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The MCO is required to notify the state of any CI including homicide, attempted homicide, suicide, the unexpected death of a consumer, abuse or neglect of an enrollee by an employee or volunteer. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system. The MCO must submit the report during the business day in which the MCO becomes aware of such an event.<br><br>The MCO is required to maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. The MCO is required to assist the state in efforts to evaluate and improve the availability and utility of selected mortality information for QI purposes. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>The MCO is required to have mechanisms to detect both under utilization and over utilization of services. |

| Element | Description/Notes |
|---|---|
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>Members have the right to file appeals regarding actions taken by the MCO to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the MCO which impair the quality, timeliness, or availability of benefits. Grievances may be written or verbal expression of dissatisfaction about an action taken by the MCO or service provider. A provider may not file a grievance on behalf of an enrollee.<br><br>The MCO is required to provide a report of completed actions, grievances, appeals and independent reviews to the state in accordance with the state's Grievance System Reporting Requirements. All grievances are to be recorded and counted whether the grievance is remedied by the MCO immediately, or through its grievance and quality of care service procedures. |
| | **h. Other.**<br><br>None specified. |
| 2. LTSS Performance Measures Requirements | LTSS performance measures required by the state focus on:<br>• Antidepression medication management.<br>• Follow-up after hospitalization for mental Illness.<br>• Drugs to be avoided in the elderly.<br>• Falls.<br>• Number of screens conducted on a quarterly basis.<br>• Quality of preparation offered to patients for post-hospital care. |
| 3. PIP Requirements | The MCO is required to conduct at least 5 PIPs of which at 2 are non-clinical. |
| 4. EQRO Requirements | The MCO's quality program shall be examined using a series of required validation procedures conducted by the state or the EQRO. This includes PIPs, performance measures, and a review of standards established by the state. The state also reserves the right to include additional optional activities if additional funding becomes available and as mutually negotiated between the state and the MCO.<br><br>The MCO is required to submit to annual EQRO monitoring review using data collection tools and methods to assesses the MCO's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by the MCO. In addition, the contract monitoring tool shall include specific contract regulations relating to MH, long-term care, and chemical dependency.<br><br>The MCO is required to provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, are used to identify and correct problems and to improve care and services to enrollees. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>The MCO is required to provide an initial screening and needs assessment but contract does not specify whether a uniform tool must be used. However the MCO is required to conduct a screening for dementia using the state's approved dementia screening tool. |
| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |

| Element | Description/Notes |
|---|---|
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>None specified. |
| | **d. LTSS/acute care coordination requirements.**<br><br>The MCO is required to ensure continuity of care and if possible and reasonable, shall preserve enrollee provider relationships through transitions. |
| | **e. Risk assessment and mitigation requirements.**<br><br>None specified. |
| 6. Ombudsman (Function) Requirements | None specified. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | None specified. |
| 9. LTSS Quality Review | The MCO is required to provide an annual report on long-term care service utilization data for enrollees must provide unduplicated counts in the following categories in dollars and the total number of unduplicated clients that received:<br>• Personal care;<br>• Environmental modification;<br>• PERS installation and service;<br>• Adult day care;<br>• Home-delivered meals;<br>• Home health aide;<br>• Skilled nursing;<br>• Client training;<br>• Specialized medical equipment and supplies;<br>• Nurse delegation (in-home);<br>• Adult family home;<br>• Enhanced residential care;<br>• Community transition services;<br>• Assisted living.<br><br>In addition, The MCO must track and report service days paid for all WMIP enrollees to licensed boarding homes that have an Assisted Living contract with the state. |

CI = critical incident
CMS = Centers for Medicare and Medicaid Services
DSHS = Washington Department of Social and Health Services
EQRO = external quality review organization
IT = information technology

LTSS = long-term services and supports
MCO = managed care organization
MH = mental health
PERS = Personal Emergency Response System

PIP = performance improvement project

QAPIP = Quality Assessment and Performance Improvement Plan
QI = quality improvement
SSI = Supplemental Security Income
WMIP = Washington Medicaid Integration Partnership

# APPENDIX Q. WISCONSIN FAMILY CARE

| Element | Description/Notes |
|---|---|
| State and Lead Agency | Wisconsin Department of Health Care Services, Division of Long-Term Care |
| Program | Family Care |
| Inception | 1999 |
| Year LTSS Added | 1999 |
| Medicaid Authority | 1915(b)/(c) |
| # Enrolled | 33,141 |
| Group Enrolled | IDD, aged and physically disabled. |
| 1. MCO Quality Management Infrastructure | **a. Staffing requirements for quality oversight/reporting.**<br><br>MCO's are required to have a governing board accountable for the MCO's QM program, a manager responsible for implementation of the QM plan with authority to deploy the resources committed to it, and a QM committee or other coordinating structure. The QM committee includes both administrative and clinical personnel to facilitate communication and coordination among all aspects of the QM program and between other functional areas of the organization that affect the quality of service delivery and clinical care. |
| | **b. Staffing and processes for provider monitoring and associated reporting requirements.**<br><br>MCOs are required to create a means for MCO staff and providers, including attendants, informal caregivers, and long-term care and health care providers with appropriate professional expertise to participate in the QM program. MCO are required to monitor the performance of subcontracted providers and collect evidence that both licensed/certified providers and non-licensed/non-certified providers continuously meet required licensure, certification, or other standards and expectations, including caregiver background checks, education or skills training, and reporting of CIs to the MCO. If the MCO identifies deficiencies or areas for improvement, the MCO and the provider(s) shall take corrective action. |
| | **c. Staffing and processes for care coordinator monitoring and associated reporting requirements.**<br><br>The MCO will conduct an ongoing program of reviews that collects evidence that:<br>• Appropriate risk assessments are performed on a timely basis.<br>• Members participate in the preparation of the care plan and are provided opportunities to review and accept it.<br>• MCPs address all participants' assessed needs (including health and safety risk factors) and outcomes.<br>• MCPs are updated and revised in accordance with the applicable standards for timeliness and when warranted by changes in the members' needs and outcomes.<br>• Services are delivered in accordance with the type, scope, amount, and frequency specified in the MCP.<br>• Members are afforded choice among covered services and providers. |

| Element | Description/Notes |
|---|---|
| | **d. IT requirements in support of quality monitoring and reporting.**<br><br>MCOs are required to maintain an information system that collects, analyzes, integrates, and reports data to support the objectives of the QM program. The system must provide information on areas including grievances, appeals, and disenrollments. It also includes systematic data related to:<br>• Achievement of member outcomes.<br>• Performance indicators for internal use that are relevant and timely for QM purposes.<br>• Interpretation of the indicators to care managers and providers. |
| | **e. CI investigation processes and associated reporting requirements.**<br><br>The state defines a CI as a circumstance, event or condition resulting from action or inaction that is either associated with suspected abuse, neglect, financial exploitation, other crime, a violation of member rights, or any unplanned, unapproved use of restrictive measures; or that resulted in serious harm to the health, safety or well-being of a member, substantial loss in the value of the personal or real property of a member; resulted in the unexpected death of a member; or posed an immediate and serious risk to the health, safety, or well-being.<br><br>The MCO is required to adopt and carry out policies governing the processes used for identification, review and analysis of each CI to ensure that CIs are reported to designated MCO staff by providers or by MCO staff within 1 business day after the incident or death was discovered. MCOs are required to take steps immediately to prevent further harm. Incidents where there is a potential violation of criminal law are reported to local law enforcement authorities. Incidents meeting protective service criteria are reported in accordance with the applicable statute to the appropriate authority.<br><br>This investigation shall be completed within 30 calendar days unless information or findings necessary for completion of the investigation cannot be obtained within that time for reasons outside of the MCO's control, in which case the investigation should be completed as promptly as possible.<br><br>The MCO is required to have designated staff to conduct CI investigations to determine:<br>• Whether the reported incident occurred and the facts of the reported incident.<br>• The type and extent of harm experienced by the member.<br>• Any actions that were taken to protect the member and to halt or ameliorate the harm.<br>• Whether reasonable actions by the provider or others with responsibility for the well-being of the member would have prevented the incident.<br>• Whether any changes in the MCO's or provider's policies or practices might prevent occurrence of similar incidents in the future. |

| Element | Description/Notes |
|---|---|
| | MCOs are required to have an ongoing program of collecting information about adverse events, monitoring for patterns or trends, and using that information in the QM program. MCOs are required to compile and submit quarterly report to the state on information related to its identification of and response to CIs, the date the MCO incident analysis was completed and a brief description of any policies or standard practices that have been or will be changed or adopted to prevent similar incidents in the future. |
| | **f. Mechanisms for monitoring receipt of community LTSS and associated reporting requirements.**<br><br>The MCO is required to have a QM program that include processes to:<br>• Monitor and detect under utilization and over utilization of services.<br>• Assess the quality and appropriateness of care furnished to members.<br>• Have appropriate health professionals reviewing the provision of health services.<br>• Provide for systematic data collection of performance and results.<br>• Provide for making needed changes. |
| | **g. Mechanisms for handling complaints/grievances/appeals, and associated reporting requirements.**<br><br>MCOs are required to have a grievance and appeal system that is responsive to concerns raised by members. The MCO must dispose of each grievance and resolve each appeal, and provide notice of a final decision, as expeditiously as the member's health condition requires, within timeframes that may not exceed the state established timeframes. |
| | **h. Other.**<br><br>**Use of Isolation, Seclusion and Restrictive Measures**--MCOs and its subcontracted providers are required to follow the states' written guidelines and procedures on the use of isolation, seclusion and restrictive measures in community settings, and follow the required process for approval of such measures.<br><br>**24-Hour Coverage**--The MCO is responsible 24/7 for providing members with services necessary to support outcomes including immediate access to urgent and emergency services to protect health and safety, access to services in the benefit package and linkages to protective services. |
| 2. LTSS Performance Measures Requirements | The contract states that the state may specify MCO performance measures. The MCO is required to specify 1 or more quality indicators specified for each PIP. |

| Element | Description/Notes |
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| 3. PIP Requirements | MCOs are required to work with the state and EQRO to complete PIPs using a performance improvement model or method based on the state's defined process. While the PIP is in the planning stage, the MCO must submit the study questions and the project aims or goals to be reviewed by the state or the EQRO. PIPs must be approved by the state. MCOs are required to submit interim reports and document ongoing progress.<br><br>Each PIP must clearly define a focus area that relates to the demographic characteristics and to the prevalence and potential consequences of the desirable or undesirable conditions among the MCO's membership. The planned improvements should affect either a significant portion of the members or a clearly specified sub-portion. The focus area should be selected on the basis of data collection and analysis of members' needs, care, and services, or on the basis of member input. MCO's PIPs address a broad spectrum of key aspects for member care and services in both clinical and non-clinical focus areas.<br><br>Each year, the MCO shall make active progress on at least 1 PIP relevant to long-term care, and for those MCOs that include primary and acute care in the benefit package, 1 additional PIP relevant tor primary and acute care. The MCO may satisfy this requirement by actively participating in a collaborative PIP in conjunction with 1 or more MCOs. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of the PIP in aggregate to produce new information on quality of care every year. The state may require specific topics for PIPs and specify performance measures.<br><br>The MCO are required to report annually to the state on the status and results of each PIP. |
| 4. EQRO Requirements | The MCO is subject to an annual external independent review of quality outcomes, timeliness, and access to the services covered in the benefit package. The MCO must assist EQRO in identifying and collecting information required to carry out on-site or off-site reviews and interviews with MCO staff, providers, and members.<br><br>In the event that a review by the EQRO results in findings that concern the state, the MCO will cooperate in further investigation or remediation, which may include:<br>• Revision of a care plan or any of its elements for correction, if found to be incomplete or unsatisfactory.<br>• Corrective action within a timeframe to be specified in the notice, if the effect on the member is determined to be serious.<br>• Additional review to determine the extent and causes of the noted problems.<br>• Action to correct systemic problems that are found to be affecting additional members. |
| 5. Care Coordination Requirements | **a. Assessment tool requirements.**<br><br>Each MCO is required to use an assessment tool developed or approved by the state to document the information collected to assess the availability and stability of the participant's informal and supports and community supports, the member's preferred living situation and a risk for the stability of housing and finances. MCOs are required to document the member's outcomes, clinical and functional concerns. |

| Element | Description/Notes |
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| | **b. Care coordinator to LTSS member ratio requirement.**<br><br>None specified. |
| | **c. Frequency and nature of LTSS member monitoring.**<br><br>MCOs are required to conduct a face-to-face visit with a member during each quarter of the calendar year. After the first 6 months of enrollment, if MCO staff has established a relationship with the member staff can waive the minimum standard but a member must receive at least 1 face-to-face visit each year. |
| | **d. LTSS/acute care coordination requirements.**<br><br>As part of an IDT, MCO Care Managers provide individualized assessment and care planning, authorizing, arranging and coordinating services in the MCP and periodic reassessments and updates of the MCP. The comprehensive assessment includes an initial and ongoing member-centered planning process employed by the IDT to identify the member's outcomes and the services and supports needed to help support those outcomes. It includes an ongoing process of using the knowledge and expertise of the member and caregivers to collect information about the member's:<br>• Needs, strengths and outcomes.<br>• Resources, informal supports and community connections.<br>• Close family members and friends.<br>• Ongoing conditions or other risk factors that require a course of treatment or regular care monitoring.<br>• Preferences for the way in which the services and supports will be delivered.<br><br>Care management also includes assistance in filing grievances and appeals, maintaining eligibility, accessing community resources and obtaining advocacy services. |
| | **e. Risk assessment and mitigation requirements.**<br><br>MCOs are required to have policies and procedures in place regarding member safety and risk which shall be submitted to the state for approval. These policies and procedures shall identify how IDT staff will assess and respond to risk factors affecting members' health and safety and guidelines for use by IDT staff in balancing member rights with member safety through a process of ongoing negotiation and joint problem solving.<br><br>MCOs are required to develop a MCP to identify clinical and functional needs of the member identified by the MCO IDT which the member may not want to receive assistance with at this time, but for health and safety reasons the IDT staff need to recognize and attempt to mitigate.<br><br>MCOs are also required to have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure that the MCO offers individualized supports to facilitate a safe environment for each member. The MCO shall assure its performance consistent with the understanding of the desired member outcomes and preferences. The MCO is required to include family members and other informal supports when addressing safety concerns per the member's preference. |

| Element | Description/Notes |
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| 6. Ombudsman (Function) Requirements | MCO must designate a "Member Rights Specialist" who is responsible for assisting members when they are dissatisfied and offering assistance to members in submitting grievances or appeals and may be responsible for scheduling and facilitating meetings. The Member Rights Specialist may not represent the MCO at a hearing of the MCO grievance and appeal committee, in a state review or at a fair hearing. In addition, MCOs are required to provide members with a Member Handbook which includes information about Ombudsman and independent advocacy services available as sources of advice, assistance and advocacy. |
| 7. Quality-Related Financial Incentives | None specified. |
| 8. Experience of Care/ Satisfaction Feedback Requirements | MCOs are required to survey members or a representative sample of members to identify their level of satisfaction with the MCO's services. This survey shall include a set of standard questions provided by the state and the MCO shall compile these results and provide them to the state. |
| 9. LTSS Quality Review | Each year, MCOs must develop a QM work plan that outlines the scope of activity and the goals, objectives, timelines, and responsible person for the QM work plan for the contract period. The work plan will also contain evidence of the MCO's commitment of adequate resources to carry out the program. MCOs are required to submit quarterly reports that includes an analysis and trends of the following components:<br>• Copies of newspaper or magazine articles about the MCO that appeared during the quarter.<br>• CI response reports.<br>• Appeal and grievance summary and logs.<br>• Provider appeals log.<br><br>MCOs are required to maintain documentation of the following activities:<br>• Annual QM work plan and its approval by the governing board.<br>• Monitoring the quality of assessments and MCPs.<br>• Monitoring the completeness and accuracy of completed functional screens.<br>• Member satisfaction surveys.<br>• Provider surveys.<br>• Response to CIs.<br>• Monitoring adverse events, including appeals and grievances that were resolved as requested by the members.<br>• Monitoring access to providers and verifying that the services were actually provided.<br>• PIPs.<br>• Results of the annual evaluation of the QM program. |
| 10. Other | **QM Plan**--MCOs are required to develop an annual QM plan based on findings from QA and improvement activities included in the QM program. The MCO shall evaluate the overall effectiveness, including the impact, of its QM program annually to determine whether the program has achieved significant improvement, where needed, in the quality of service provided to its members. |

CI = critical incident
EQRO = external quality review organization
IDD = intellectual and developmental disabilities
IDT = interdisciplinary team
IT = information technology

LTSS = long-term services and supports
MCO = managed care organization
MCP = member-centered plan
PIP = performance improvement project
QA = quality assurance

QM = quality management

# STUDY OF MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS: LESSONS LEARNED FROM EARLY IMPLEMENTERS

## Reports Available

Addressing Critical Incidents in the MLTSS Environment: Research Brief
- HTML http://aspe.hhs.gov/daltcp/reports/2013/CritIncidRB.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/CritIncidRB.pdf

Did They or Didn't They?: A Brief Review of Service Delivery Verification in MLTSS
- HTML http://aspe.hhs.gov/daltcp/reports/2013/verifyRB.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/verifyRB.pdf

Environmental Scan of MLTSS Quality Requirements in MCO Contracts
- Executive Summary http://aspe.hhs.gov/daltcp/reports/2013/MCOcontres.shtml
- HTML http://aspe.hhs.gov/daltcp/reports/2013/MCOcontr.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/MCOcontr.pdf

How Have Long-Term Services and Supports Providers Fared in the Transition to Medicaid Managed Care? A Study of Three States
- Executive Summary http://aspe.hhs.gov/daltcp/reports/2013/3LTSStranses.shtml
- HTML http://aspe.hhs.gov/daltcp/reports/2013/3LTSStrans.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/3LTSStrans.pdf

Participant-Directed Services in Managed Long-Term Services and Supports Programs: A Five State Comparison
- Executive Summary http://aspe.hhs.gov/daltcp/reports/2013/5LTSSes.shtml
- HTML http://aspe.hhs.gov/daltcp/reports/2013/5LTSS.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/5LTSS.pdf

Performance Measures in MLTSS Programs: Research Brief
- HTML http://aspe.hhs.gov/daltcp/reports/2013/PerfMeaRB.shtml
- PDF http://aspe.hhs.gov/daltcp/reports/2013/PerfMeaRB.pdf

Quality in Managed Long-Term Services and Supports Programs

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|---|---|
| Executive Summary | http://aspe.hhs.gov/daltcp/reports/2013/LTSSquales.shtml |
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/LTSSqual.shtml |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/LTSSqual.pdf |

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

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