Coordinated System of Care

Quality Improvement Strategy

December 2015

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Coordinated System of Care

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Overview

The Coordinated System of Care is designed to provide services and supports to children and youth, who have significant behavioral challenges or co-occurring disorders, and are in or at imminent risk of out-of-home placement. The Coordinated System of Care (CSoC) integrates resources from all Louisiana's child-serving agencies, including the Department of Health and Hospitals (DHH), Department of Education (DOE), Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ).

The family-driven and coordinated approach of CSoC is meant to create and oversee a service delivery system that is better integrated, has enhanced service offerings and achieves improved outcomes by ensuring families who have children with severe behavioral health challenges get the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider, to keep or return children home or to their home communities. Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers and others who support the family.

The goals of the CSoC include:

- Reduce state's cost of providing services by leveraging Medicaid and other funding sources as well as increasing service effectiveness and reducing duplication across agencies,
- Reduce out of home placements in the current number and future admissions of children and youth with significant behavioral health challenges and co-occurring disorders, and
- Improving the overall outcomes of children and their caretakers.

DHH contracts with a Prepaid Inpatient Health Plan, referred to as the CSoC Contractor, which is responsible for coordinating, administering, and managing specialized behavioral health services for Medicaid-eligible children and youth potentially eligible for or enrolled in the Coordinated System of Care (CSoC) waiver.

What We Believe

Children and families are most likely to succeed when all people working on behalf of young people and their families are guided by the following values:

- Family driven
- Youth guided
- Culturally and Linguistically Competent *(in a way that the family is comfortable)*
- Home and Community based
- Strength-based
- Individualized
- Integrated Across Systems *(bringing agencies, schools and providers together to work with families)*
- Connected to Natural Helping Networks
- Data driven and outcomes oriented
- Unconditional Care

History

Prior to the implementation of the CSoC, Louisiana leaders acknowledged that the needs of at-risk children and families were being served through a fragmented service delivery model, which was, at many times, inadequate and difficult to navigate.

In 2009, initial planning meetings were held with participation from over 40 agency and stakeholder leaders, including parents, advocates, providers and community leaders to determine the goals, values and population of focus for the CSoC. Following the retreat, the CSoC leadership team was formalized to include representatives from the Governor's Office, OJJ, DCFS, DOE, DHH and the Federation of Families for Children's Mental Health, a parent/advocate and an executive of a human service district. The leadership team then established a planning group comprised of 30 individuals representing all four state agencies, the Governor's Office, juvenile court, advocacy organizations, providers and parents, with over 40% of the membership as external stakeholders.

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

The leadership team outlined an implementation plan in August 2010, based on a multi-departmental, family inclusive governance entity. Additional major components of the CSoC structure were the establishment of local care management entities and partnerships with family support organizations.

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

Implementation of CSoC was a two phase process, with the state being divided into nine regions. Phase One of implementation kicked off with a 'go live' date in March of 2012, with the selection of four regional wraparound agencies, each serving one of the 5 selected regions, with a capacity to serve up to 1,200 children, youth and families. Phase two began in September of 2014 when CMS granted the state approval for statewide implementation and the remaining 4 regions were brought on, with an increased capacity to serve up to 2,400 children, youth and families at any given time. Since March 2012, over 6,000 children and youth have been enrolled in CSoC.

Purpose of the Quality Improvement Strategy

The Quality Improvement Strategy provides a description of the monitoring process and standards of care used to assess and improve the quality of managed care services offered by the CSoC Contractor. The specific state

and federal requirements that must be met by the CSoC Contractor are detailed in the Request for Proposals, corresponding contract, and the CSoC waiver authority documents.

The Department of Health and Hospitals has structured the CSoC quality improvement system to address federal and state requirements and to meet the goals of the home and community-based quality framework and the Triple Aim. This structure also ensures stakeholders are active in the quality improvement process and includes several key committees tasked with quality monitoring:

- The CSoC Governance Board is comprised of executives of the Department of Children and Family Services, Department of Education, Office of Juvenile Justice, Department of Health and Hospitals, a representative from the Governor's Office, and family, youth and other advocates, who meet at least four times annually, and is responsible for:
  - Overseeing the implementation and administration of the CSoC,
  - Setting policy for the governance of the CSOC,
  - Establishing policy and monitoring adherence
  - Setting standards,
  - Directing use of multiple funding sources,
  - Directing the implementing agency, and
  - Monitoring quality, cost, and adherence to standards.
- The Interdepartmental Monitoring Team is comprised of subject matter experts from the Office of Behavioral Health, Bureau of Health Services Financing (Medicaid), Department of Education, Department of Children and Family Services, and the Office of Juvenile Justice who meet at least quarterly to:
  - Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to determine patterns, trends, concerns, and issues in service delivery
  - Provide oversight and monitoring of corrective action plans
  - Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities
- The Executive Office of Behavioral Health/Bureau of Health Care Financing Joint Committee is comprised of executive level staff of the OBH and BHSF (Medicaid) for the purpose of:
  - Ensuring federal quality requirements and program goals are met,
  - Adopting quality standards and measures,
  - Taking action on recommendations from the Interdepartmental Monitoring Team and CSoC Governance Board,
  - Establishing priorities and allocating resources,

- Establishing workgroups to design, coordinate, and integrate improvement strategies
- Troubleshooting critical issues

The QIS will be reviewed at least annually by the IMT and revised based on results of analyses.

Assessment: Quality and Appropriateness of Care

Procedures for Race, Ethnicity, Primary Language, and Data Collection

The five racial categories for which data are gathered are: American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Black/African American and White. The two ethnic categories are: Hispanic or Latino and Non-Hispanic or Latino. When individuals fail to self-identify, alternative system checks and follow-up with households are executed. If a racial and/or ethnic category cannot be obtained, the identification defaults to "Unknown".

During the Medicaid and CHIP application process, the applicant may identify race, ethnicity, and primary spoken language. The data collected for race and language is processed through the Medicaid Eligibility Data System (MEDS) and downloaded nightly into the Medical Management Information System (MMIS) Recipient Subsystem. The applicant's preferred language is also identified and forwarded to the MMIS. Because this is a voluntary disclosure, until the Medicaid eligibility process implements mandatory disclosure of race/ethnicity and primary language, the State relies on demographic updates to the eligibility system. Although this method does not collect 100% of the required data, there are data for a significant portion of the population served. Through ten years of collecting data via the Medicaid/CHIP application form on preferred spoken and written languages, Louisiana has determined that Spanish and Vietnamese are the two most common foreign languages in which written materials are requested. In addition, the Contractor is required to have a sufficient number of qualified oral interpreters, bilingual staff, and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats, including formats available to the visually impaired.

Mechanisms the State Uses to Identify Persons with Special Health Care Needs

The State has determined that all CSoC members have specialized health care needs.

National Performance Measures

At this time, CMS has not identified any required national performance measures. However, DHH has adopted the following HEDIS-like measures for Contractor reporting purposes:

Measure	Measure Description	Reporting Frequency
Mental Health Utilization	Number and percentage of members receiving the following mental health services during any measurement year: - Any service - Inpatient	Calendar quarter

	- Intensive outpatient or partial hospitalization - Outpatient or ED	
Follow-Up After Hospitalization for Mental Illness	Number and percentage of discharges for which the member received follow-up within 7 days and 30 days of discharge	Calendar quarter

Assessment: Monitoring and Compliance

OBH has developed a number of measures designed to ensure the Contractor's adherence to federal waiver requirements, which are detailed below:

Waiver Performance Measure	Report Frequency	Data Source & Sample Size	Goal
Number and percent of initial participants who meet the level of care requirements prior to receipt of services	Quarterly	100% review; Contractor data system	90%
Number and percent of participants whose level of care determination form was completed timely as required by the State	Quarterly	100% review; Contractor data system	90%
Number and percent of participants whose level of care determination was made by a qualified evaluator	Quarterly	Representative sample; onsite record review	90%
Number and percent of providers initially meeting licensing and training requirements prior to furnishing waiver services	Quarterly	100% review; Contractor data system	100%
Number and percent of providers continuously meeting licensing and training requirements	Quarterly	100% review; Contractor data system	100%
Number and percent of non-licensed direct care staff of providers that meet State requirements	Quarterly	Representative sample; onsite record review	100%
Number and percent of participants whose plan of care reflects supports and services necessary to address the participant's goals	Quarterly	Representative sample; onsite record review	90%
Number and percent of participants whose plan of care include supports and services consistent with assessed health needs, including risks	Quarterly	Representative sample; onsite record review	90%
Number and percent of participants who participated in the plan of care development, as documented by the participant's and parents/caregiver's signature on the plan of care	Quarterly	Representative sample; onsite record review	90%
Number and percent of participants whose plans of care were updated timely, as specified in the waiver application	Quarterly	100% review; Contractor data system	90%
Number and percent of participants whose plan of care was updated when the participant's needs changed	Quarterly	Representative sample; onsite record review	90%

Number and percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care	Monthly	100% review; member self-report	90%
Number and percent of participants given a choice among service providers, as documented by the participant/authorized representative's signature on the State-approved form	Quarterly	Representative sample; onsite record review	90%
Number and percent of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State-approved form	Quarterly	Representative sample; onsite record review	90%
Number and percent of incidents involving abuse, neglect, exploitation, and death that were referred to the appropriate protective service agency for investigation within 24 hours of notification	Quarterly	100% review; Contractor data system	100%
Number and percent of critical incidents involving licensed/certified providers that were investigated by the Contractor within the established timeframe	Quarterly	100% review; Contractor data system	100%
Number and percent of participants who received information about how to report critical incidents, as documented by the participant/authorized representative's signature on the State-approved form	Quarterly	Representative sample; onsite record review	90%
Number and percent of critical incidents which did not involve the use of restraints or seclusion	Quarterly	100% review; Contractor data system	100%
Number and percent of participants who received coordination and support to resolve health needs identified through case management contacts	Quarterly	Representative sample; onsite record review	90%
Number and percent of paid claims that are coded according to the services rendered	Quarterly	Representative sample; onsite record review	90%
Number and percent of claims that paid no less than the Medicaid-approved rate	Quarterly	100% review; Contractor data system	100%
Number and percent of participants whose plan of care shows evidence that their setting meets HCBS requirements and in a provider-owned or controlled setting the additional requirements are met	Quarterly	Representative sample; onsite record review	100%
Number and percent of CSoC providers who meet the HCBS setting rule requirements	Quarterly	Representative sample; onsite record review	100%

In addition, OBH has developed a number of measures designed to ensure the goals of CSoC are met:

Report	Frequency
Children in Restrictive Settings	Quarterly

CSoC WAA Weekly report (referrals and enrollments)	Weekly
CSoC Demographics	Quarterly
Involvement with Child-Serving State Agencies	Quarterly
CSoC Length of Stay	Quarterly
CANS Outcomes	Quarterly
Living Situation at Discharge	Quarterly
Improved School Functioning	Quarterly
Access to Wraparound	Quarterly
Utilization of Natural Supports	Quarterly
Utilization of Outpatient Services	Quarterly
Fidelity to Practice	Annually
Member Satisfaction Survey	Annually

Reports to be generated by the Contractor shall meet all State and federal reporting requirements. These reports include implementation, operation, financial, clinical, and outcome measurement. The needs of the Department and other appropriate agencies for planning, monitoring, and evaluation shall be taken into account in developing report formats and compiling data.

Upon request of the Department, the Contractor may also be asked to produce additional ad-hoc reports in cooperation with other federal and/or State agencies. The Department shall incur no expense in the generation of such reports. Additionally, the Contractor shall make revisions in the data elements or format of the reports required in the contract upon request of the Department and without additional charge to the Department. The Department shall provide written notice of such requested revisions or format changes in a notice of required report revisions. The Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of the contract.

Reports shall be transferred electronically to the Department. Reports that contain protected health information (PHI) shall be transferred via a secure web service. The Contractor shall not publish any reports or data without prior, written approval from the Department.

External Quality Review

The Contractor will be evaluated annually by the State, in accordance with 42 CFR 438.204, by an independent external quality review organization (EQRO). This will include review of the services covered under the contract for timeliness, outcomes, and accessibility, using definitions contained in 42 CFR 438.320.

The scope of the annual external quality review, as mentioned in 42 CFR 438.310(b), includes: a) criteria used to select entities to perform the reviews, b) specification of activities to be performed by the EQRO, c) the circumstances in which the EQR may use other accreditation review results and d) standards for availability of review results. The annual EQR will be conducted each calendar year, with the first EQR report including any months prior to the first full calendar year of operation.

The EQRO competence and independence requirements are used as criteria in selecting an entity to perform the review, as mentioned in 42 CFR 438.354 and 42 CFR 438.356(b) and (d), using the rates, as described in 42 CFR 433.15(b)10 and 42 CFR 438.370. To ensure competence, the EQRO must have staff with demonstrated experience and knowledge of the Medicaid program, managed care delivery systems, quality management methods, and research design and statistical analysis. The EQRO must have sufficient resources to conduct needed activities and other skills necessary to carry out activities or supervise any subcontractors. To ensure independence, the EQRO must not be: an entity that has Medicaid purchasing or managed care licensing authority; governed by a body in which the majority of its members are government employees; reviewing an PIHP in which the EQRO has a control position or financial relationship by stock ownership, stock options, voting trusts, common management or contractual relationships; delivering any services to Medicaid recipients or conducting other activities related to the oversight of the quality of PIHP services, except for those specified in 438.358. EQROs are permitted to use subcontractors; however, the EQRO is accountable for, and must oversee, all subcontractor functions, as mentioned in 42 CFR 438.356(c).

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

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

CMS Mandatory EQRO activities conducted by the Louisiana EQRO, as mentioned in 42 CFR 438.358, include:

- Validate PIPs required by the State
- Validate PMs required by the State
- Review of the Contractor's compliance with the State's standards for access, structure and operations, and quality measurement and improvement

Methods outlined in the EQR protocol include:

- Desk compliance review of all policies and procedures, program descriptions, committee minutes, manuals, handbooks and quality data
- Onsite compliance visit conducted in the Contractor's Louisiana office(s) to review credentialing files, medical records, conduct staff interviews, and provide feedback
- Medicaid/treatment chart reviews
- Data analysis
- Administrative oversight and quality assessment and improvement review

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

- A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness, and access to care furnished by the Contractor. For each activity conducted, the report does include objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data.
- Recommendations for improving the quality of health care services furnished by the Contractor.
- An assessment of the degree to which the Contractor effectively addresses previous EQRO review recommendations.

The State provides copies of the EQRO results and reports, upon request, to interested parties through print or electronic media or alternative formats for persons with sensory impairments, as mentioned in 42 CFR 438.364(b). The State will provide copies of the EQRO results and reports to CMS. In addition, summary results and findings will be included in reports to the legislature and to the public, as appropriate.

EQR results and technical reports are reviewed by the IMT Committee. Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements, as well as improvements to PIPs and PMs. Report results are also used to determine levels of compliance with requirements and to assist in identifying next steps.

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

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

Performance Improvement Projects

Performance improvement projects (PIPs) are conducted to achieve improvement through ongoing measurement and intervention resulting in significant improvement, sustained over time, with favorable effect on health outcomes and enrollee satisfaction. 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 regarding quality of care every year. The quality of care projects used to measure performance improvement shall include diagrams (e.g., algorithms and/or flowcharts) for monitoring and shall:

- Target specific conditions and specific health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation.
- Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions.
- Use appropriate quality indicators derived from the clinical care standards or practice guidelines for screening and monitor of care and services delivered.
- Implement system interventions to achieve improvement in quality, including a PDSA cycle.
- Evaluate the effectiveness of the interventions.
- Provide sufficient information to plan and initiate activities for increasing or sustaining improvement.
- Monitor the quality and appropriateness of care furnished to enrollees with SHCN.
- Reflect the population served in terms of age groups, disease categories, and special risk status.
- Ensure that appropriate health professionals analyze data.
- Ensure that multi-disciplinary teams will address system issues.
- Include objectives and quantifiable measures based on current scientific knowledge and clinical experience, and have an established goal or benchmark.
- Identify and use quality indicators that are measurable and objective.
- Validate the design to ensure that the data to be abstracted during the QI project is accurate, reliable, and developed according to generally accepted principles of scientific research and statistical analysis.
- Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

In accordance with 42 CFR 438.240, Louisiana requires the Contractor to perform a minimum of one (1) State-approved PIP. The DHH recommended PIP during the first contract year will be “Increase in the Attendance of Behavioral Health Providers at the Child and Family Team Meetings,” using metrics such as the number of providers who participated in the Child and Family Team meetings as measured by the provider’s signature on the approved plan of care.

Within three (3) months of the execution of the contract, the Contractor shall submit, in writing, a description of each of the PIP topics to the Department for final review and approval. The detailed description shall include:

- An overview explaining how and why the project was selected, as well as its relevance to members and providers;
- The study question;
- The study population;
- The quantifiable measures to be used, including a goal or benchmark;
- Baseline methodology;
- Data sources;
- Data collection methodology;
- Data collection cycle;
- Data analysis cycle;

- Results with quantifiable measures;
- Analysis with time period and the measures covered;
- Analysis and identification of opportunities for improvement; and
- An explanation of all interventions to be taken.

The Contractor shall submit project analysis monthly to DHH and project outcomes annually.

The EQRO validates the PIP each year. The EQRO report summarizes the findings for the PIP, inclusive of the analysis of findings, as well as recommendations for improvement.

State and Federal Standards

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

Access Standards

Delivery Network
Contracted network of appropriate providers (42 CFR 438.206(b)(1) ▪ The Contractor must maintain a network of qualified Medicaid behavioral health and waiver service providers in sufficient numbers and locations throughout the state to provide required access to covered services. The Contractor is expected to maintain and enhance a network that provides a comprehensive array of behavioral health services with a geographically convenient flow of members among culturally-competent, qualified network providers as necessary to meet their identified needs. The provider network shall be designed to reflect the needs and service requirements of the CSoC member population and shall be supported by written provider subcontracts. ▪ The Contractor shall be required to contract with at least one Federally Qualified Health Center (FQHC) in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications. ▪ The Contractor shall also be required to maintain within their network a sufficient number of providers of specialized CSoC services including Youth Support and Training (YST), Parent Support and Training (PST), Independent Living/Skills Building (ILSB), Short Term Respite and Crisis Stabilization. ▪ The Contractor shall assure that the network has a sufficient number of prescribers and other qualified service providers to deliver services during evenings and weekends for members or their families/caregivers who are unavailable for appointments during regular business hours. ▪ The Contractor shall maintain a fully operational network of crisis response providers offering a complete array of crisis services, available 24 hours per day, 7 days per week as of the contract go-live date. The community-based crisis response system may include, but is not limited to, on-call, 24-hour hotline, warm line, crisis

counseling, behavioral management and intervention, mobile crisis team and crisis stabilization in an alternative setting.
Adequate and Timely Second Opinion (42 CFR 438.206(b)(3)) If requested, the Contractor shall offer a second opinion from a qualified healthcare professional within the network or arrange for a second opinion outside the network at no cost to the member.
Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5)) ▪ If the Contractor is not able to deliver a medically necessary covered behavioral health service, the Contractor shall timely subcontract with an out-of-network provider to deliver the same service until a network provider is available. The Contractor shall expeditiously authorize services and reimburse the out-of-network provider in these circumstances. ▪ If a member needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available. Transportation will be provided and reimbursed through Medicaid when eligible; otherwise, the Contractor shall be responsible for costs of necessary transportation in this circumstance. ▪ The Contractor must coordinate with out-of-network providers with respect to payment. The Contractor must ensure that cost to the member or state is no greater than it would be if the services were furnished within the network.
Provider Credentialing as required in regulation (42 CFR 438.206(b)(6)) ▪ Prior to contracting with the Contractor, providers must be credentialed according to the Contractor and DHH standards. DHH will certify the WAAs and the FSO for the CSoC services they offer. ▪ In the event a provider is denied credentialing by the Contractor, the Contractor will provide to DHH electronically a reason for the denial as well as applicable data supporting the denial. ▪ The credentialing through contract process should not exceed sixty (60) calendar days per application. ▪ The Contractor must have written credentialing and re-credentialing processes that comply with 42 CFR §438.12; §438.214, and §438.230 and NCQA Health Plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. ▪ The Contractor shall evaluate every prospective provider's ability to perform the activities to be delegated prior to contracting with any provider or subcontract. The Contractor must ensure the provider has not been found to have committed fraud. ▪ All subcontracted providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for members with disabilities. ▪ The Contractor is not obligated to continue to contract with a provider that does not meet the contractual standards (e.g., fails to meet all health and safety standards and maintain all required health standards licenses); does not provide high quality

services; or demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the Contractor and DHH.

- The Contractor shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §1156 (42 U.S.C. §1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The Contractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders. The Contractor shall conduct regular checks as per 42 CFR §455.436 and notify DHH of subcontracted providers found.

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

- The Contractor and its providers must meet the State standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are as follows:
  - Emergent, crisis or emergency services must be available at all times. An appointment shall be available within one (1) hour of request.
  - Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. An appointment shall be available within 48 hours of request.
  - Routine, non-urgent behavioral healthcare shall be available with an appointment within fourteen (14) days of referral.
- The Contractor shall establish mechanisms to ensure that network providers comply with the timely access requirements, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.
- The Contractor shall ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- The Contractor shall make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

Cultural Considerations (42 CFR 438.206(c)(2))

- The Contractor shall document how they meet requirements with regard to cultural competence and linguistic needs, ensuring delivery of services in a culturally competent manner to all members including access to services in the member's prevalent language(s) and in consideration of diverse cultural and ethnic backgrounds in accordance with 42 CFR §438.206.

- The Contractor shall collect demographic data, including but not limited to ethnicity, race, gender, sexual orientation, and religion, so that the provider will be able to respond appropriately to the cultural needs of the community being served.
- The Contractor shall assess the cultural competency of its providers at least annually.
- The Contractor shall assess member satisfaction of the services provided as it pertains to cultural competency at least annually.
- The Contractor shall require and provide training on cultural competence, including tribal awareness to Contractor staff and network providers for a minimum of three (3) hours per year and as directed by the needs assessment.

Assurances of Adequate Capacity 438.207

Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c))

The Contractor shall ensure its provider network offers an appropriate range of specialty behavioral health services that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements.

Coordination and Continuity of Care 438.208

- The Contractor shall ensure that mechanisms are implemented to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing conditions that require a course of treatment or regular care monitoring. The assessment mechanism shall incorporate appropriate health care professionals.
- The Contractor shall require each provider to implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify special conditions of the enrollee that require a course

Primary care and coordination of health care services for all enrollees.

The Contractor shall support the integration of physical and behavioral health services and will work in conjunction with Bayou Health.

The Contractor shall implement measures that ensure effective co-management and information sharing between Bayou Health Plans and the Contractor, inclusive of the following:

- Documenting the member's PCP in the Care Management record or, if none, follow up on the PCP referral as part of the ongoing care management process, thus ensuring that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member.
- Providing or arranging for training of Contractor providers and Care Managers on identification and screening of medical/physical health conditions and referral procedures.

- Conducting Case Management rounds at least monthly with each Bayou Health plan.
- Coordinating services that the Contractor furnishes to the member with the services the member receives through Bayou Health including access to pharmacy needs.
- Timely sharing of clinical information relative to the member's needs with Bayou Health Contractor in order to prevent duplication of those activities.
- Ensuring that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and §164.

Mechanisms for Members with SHCN: Development of Treatment

Plans (42 CFR 438.208(c)(3))

The function of the Wraparound Facilitator is to produce a community-based, individualized treatment plan. This includes working with the individual and/or family to identify who should be involved in the treatment planning process. The WF guides the treatment plan development process. The WF also is responsible for subsequent treatment plan review and revision as needed, under 1915(b), and 1915(c) guidelines, to review the treatment plan and more frequently when changes in the member's circumstances warrant changes in the treatment plan. The WF will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the child or adult and family/caregivers.

Coverage and Authorization of Services 438.210

- The Contractor is required to provide core benefits and services identified in the contract and ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.
- The Contractor shall limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Vol. 37, No. 1) for medical necessity determinations.
- The Contractor shall use the state Medicaid definition of "medically necessary services" in a manner that is no more permissive or restrictive than the state Medicaid program. All services for which a member is eligible shall at a minimum cover the prevention, diagnosis, and treatment of behavioral health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.

Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3))

- The Contractor shall have staff with clinical expertise and training to apply service authorization criteria, including but not limited to the application of the CANS algorithm to determine clinical eligibility, based on medical necessity and practice

guidelines. Determinations of service authorization must be made by qualified and trained LMHPs in accordance with state and federal regulations.

- The Contractor shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for service authorization determinations. The Contractor shall make service authorization determinations that are consistent with the state's definition of medical necessity.
- The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the reviewer's physical, mental, professional or moral character.
- The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise

Notice of Adverse Action (42 CFR 438.210(c))

- The Contractor shall notify the member in writing, using language that is easily understood at a fifth-grade reading level, of decisions and reasons to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 16 of this contract. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) for member written materials. The notice shall contain information regarding the Contractor's grievance and appeals process.
- The Contractor shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested within one (1) working day as per RS 22:1128.

Timeframe for Decisions (42 CFR 438.210(d))(1), (2)&(e)

There shall be 24-hour, 7 days per week, 365 days per year capacity for service authorization by LMHP care managers.

Standard Service Authorization

- As per 42 CFR §438.210(d), the Contractor shall provide notice as expeditiously as the member's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service unless an extension is requested. As per the 1915(b) waiver and 42 CFR §438.206, the Contractor shall ensure its providers meet established standards for timely access to care and services, taking into account the urgency of the need for services.
- An extension may be granted for service authorization determination for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the Contractor justifies to DHH a need for additional information and the extension for service authorization determination is in the member's best interest. In no instance shall any determination of standard service authorization be made later than twenty-eight (28) calendar days from receipt of the request.

- The Contractor shall make concurrent review determinations within timeframes established under URAC accreditation timeline requirements for each LOC after obtaining the appropriate medical information that may be required.

Expedited Service Authorization

- In the event a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than three (3) calendar days after receipt of the request for service.
- The Contractor may extend the three (3) calendar day time period by up to fourteen (14) calendar days when there is serious jeopardy to the member's life or health and if the member or Contractor justifies to DHH a need for additional information and how the extension is in the member's best interest

Structure and Operations Standards

Provider Selection
Selection and Retention (42 CFR 438.214(a), (b)(2)) ▪ The Contractor must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the Contractor.
Nondiscrimination (42 CFR 438.214(c)) (42 CFR 438.12(a)) ▪ The Contractor's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. ▪ The Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. ▪ The Contractor shall clearly describe and disseminate the process and criteria to be used for terminating provider participation. If the Contractor declines to subcontract with individuals or groups of providers as part of the network, it shall give the affected providers prior written notice of the reason for its decision. ▪ In the event a provider is denied credentialing by the Contractor, the Contractor will provide to DHH electronically a reason for the denial as well as applicable data supporting the denial. ▪ Upon receipt and review of the above requirements from the Contractor for the provider, DHH will review the attestation and recommendation and notify the Contractor that the provider is eligible for contracting in writing or via electronic mail. The Contractor will have thirty (30) calendar days to sign the contract with the provider from the date DHH certifies the provider for contracting. **(42 CFR 438.12 (b)(1))**

The Contractor will not be required to contract with providers beyond the number necessary to meet the needs of the members.

(42 CFR 438.12(b)(3))
The Contractor is not precluded from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members.

Excluded Providers (42 CFR 438.214(d))
The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

State Requirements (42 CFR 438.214(e))
The Contractor must comply with any additional requirements established by the State.

- The Contractor shall be required to contract with at least one Federally Qualified Health Center (FQHC) in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications

Confidentiality 438.224

Confidentiality requirements consistent with (42 CFR 438.224), (45 CFR parts 160 and 164)

- The Contractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this contract. The Contractor's written safeguards shall:
  - Be comparable to those imposed upon DHH by 42 CFR Part 431, Subpart F and La.R.S. 46:56;
  - State that the Contractor will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
  - Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;
  - Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
  - Specify appropriate personnel actions to sanction violators

- The Contractor shall assure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the Contractor's performance under this contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 and other state and federal laws, DHH policies or this contract. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this contract.

▪ The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The Contractor shall ensure compliance with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.
Enrollment and Disenrollment
Enrollment and Disenrollment (42 CFR 438.226) The Contractor must ensure that its contract complies with the enrollment and disenrollment requirements and limitations set forth in § 438.56. Disenrollment: Requirements and Limitations (42 CFR 438.56) ▪ The Contractor shall not request disenrollment of any member who is eligible for CSoC services because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. ▪ The Contractor may not disenroll CSoC members for any reason other than discharge from CSoC. Eligible recipients may choose to no longer participate in CSoC in which case specialized behavioral health services will be transitioned to Bayou Health Contractor effective the first day of the month following discharge. The state will disenroll effective the 1st day of a month members who lose Medicaid eligibility.
Prohibited discrimination 438.6(k)(4)
The Contractor shall not discriminate in the enrollment of Medicaid individuals into the Contractor. The Contractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the Contractor's program or be otherwise subjected to discrimination in the performance of this contract or in the employment practices of the Contractor. The Contractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.
Grievance Systems 438.228
Grievance Systems (42 CFR 438.228(a)) The Contractor must have a grievance system in place that meets the requirements of Subpart F of Part 438 – Managed Care.
Statutory Basis and Definitions 438.400 ▪ The Contractor is required to establish and maintain internal grievance system procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage, or payment for, medical assistance. ▪ An "action" shall be defined as: o Denial or limited authorization of a requested service, including the type or level of service; o Reduction, suspension, or termination of a previously authorized service; o Denial, in whole or in part, of payment for a service;

- Failure to provide services in a timely manner, as defined by the State or act within the timeframes of 438.208;

- *Appeal* means a request for review of an action as defined in this section.
- *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in the section. The term is also used to refer to the overall system that includes grievances and appeals handled at the Contractor level and access to the State fair hearing process.

General Requirements 438.402

Grievance System (42 CFR 438.402 (a))
The Contractor must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system.

Authority to File (42 CFR 438.402(b))

- A member, or authorized representative acting on the member's behalf, may file a grievance and Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted.
- A network provider, acting on behalf of the member and with the member's written consent, may file a grievance. The provider may also file a Contractor level appeal and may request a State Fair Hearing on behalf of a member with written consent, once the Contractor's appeals process has been exhausted.
- A provider may file an appeal of an action including, but not limited to, denied claims.

Timing (42 CFR 438.402(b)(2))

- Within thirty (30) calendar days from the date on the Contractor's notice of action or inaction, the member or a representative acting on their behalf must be allowed to file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.
- The member, the member's representative, or the provider on the member's behalf with written consent, may file a grievance at any time.

Procedure (42 CFR 438.402(b)(3))

- The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file a grievance either orally or in writing with the Contractor.
- The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow the oral filing with a written, signed appeal request.

Notice Of Action 438.404, 438,200, 438.228, 438.206

42 CFR 438.228, 431.206(b) and 431.210:
The Contractor has delegated responsibility for State Fair Hearing notices.

Notification of State Procedures (42 CFR 438.200(b))

- The Contractor shall ensure that all members and providers are informed of the Contractor's grievance and appeal procedures and the State Fair Hearing process.
- The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures

Language and Format (42 CFR 438.404(a), 42 CFR 438.10(c) and (d)) Language:

- The notice must be in writing and must meet the language and format requirements of 42 CFR §438.10(c) and (d) to ensure ease of understanding. Specifically, the notice shall be translated and provided in the language spoken by the member with notice that translation services are available free of charge to the member if needed.
- Notice of Action letters must be approved by DHH prior to use or changes.

Notice of Adverse Action Content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210 The Notice of Action must explain the following:

- The action the Contractor has taken or intends to take;
- The reasons for the action;
- The member's or the provider's right to file an appeal with the Contractor;
- The member's right to request a State Fair Hearing, after the Contractor's appeal process has been exhausted;
- The procedures for exercising the rights specified in this section;
- The circumstances under which expedited resolution is available and how to request it;
- The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and
- Oral interpretation is available for all languages and how to access it.

Timeframes for Notice of Action: (42 CFR 438.404(c)(1))

Termination, Suspension, or Reduction of Services

For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except as permitted under 42 CFR §431.213 and §214.

Timeframes of Notice of Action (42 CFR 438.404(c)(2), (3), (4), (5)&(6)) Untimely Service

Authorization Decisions

- The Contractor is required to give notice on the date that timeframes expire if service authorization decisions are not reached for either standard or expedited service requests. Untimely service authorizations constitute a denial and are considered adverse actions. For denial of payment, the Contractor is required to give notice at the time of any action affecting the claim.
- For standard service authorization decisions, (42 CFR 438.210 (d) (1)), that deny or limit services, notification occurs within the timeframe specified in Coverage and Authorization of Services.
- If the Contractor is granted an extension, the enrollee must be given written notice of the extension, and be offered the opportunity to file a grievance if they disagree with the decision. The Contractor must carry out the decision as expeditiously as the

enrollee's health condition requires and no later than the date the extension expires.

- For service authorization decisions not reached within the timeframes (which constitutes a denial and is thus an adverse action), notification occurs on the date that the timeframes expire.
- For expedited service authorization decisions, notification occurs within the timeframe specified in Coverage and Authorization of Services.

Handling of Grievances and Appeals 438.406

General Requirements (42 CFR 438.406(a)

- The Contractor's grievance and appeals process must be approved by the State. The appeals process shall consist of an informal internal review by the Contractor (Stage 1 appeal) and a formal internal review by the Contractor (Stage 2 appeal). The enrollee always has the right to appeal to DHH, whether or not they have filed an appeal with the Contractor.

- The Contractor will provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- The Contractor will acknowledge the receipt of each grievance and appeal in writing within three (3) business days of receipt.
- The Contractor shall complete the investigation and final resolution process for grievances within thirty (30) calendar days or less (as per applicable waivers) of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant
- The Contractor will ensure that the individuals who make decisions on grievances and appeals are individuals:
    - Who were not involved in any previous level of review or decision-making; and
    - Who, if deciding any of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:
        - An appeal of a denial that is based on lack of medical necessity.
        - A grievance regarding denial of expedited resolution of an appeal.
        - A grievance or appeal that involves clinical issues

Special Procedures – The Process for Appeals (42 CFR 438.406(b))

The enrollee or provider may file an appeal either orally or in writing and must follow the oral filing with a written, signed appeal.

The Contractor must:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or provider requests expedited resolution;

- Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing and inform the enrollee of the limited time for this in the case of an expedited resolution;
- Allow the enrollee and representative the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records
- Consider the enrollee's representative, or estate representative of a deceased enrollee as parties to the appeal

Resolution and Notification: Appeals 438.408

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

- The Contractor must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires but within the State established timeframes not to exceed thirty (30) calendar days from the day the CONTRACTOR receives the appeal.
- For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the Contractor receives the appeal.
- For expedited resolution of an appeal and notice to affected parties, the timeframe is established as three (3) working days after the Contractor receives the appeal.

The Contractor may extend the timeframes of this section by up to fourteen (14) calendar days if:

- The member requests the extension; or
- The Contractor shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.

If the Contractor extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

Format and Content of Resolution Notice (42 CFR 438.408(d)(e))

The Contractor will provide written notice to the member of the disposition of a grievance via a letter to the originator of the grievance containing, at a minimum:

- Sufficient detail to foster an understanding of the quality of care resolution, if grievance was a quality of care issue;
- A description of how the member's behavioral healthcare needs will or have been met; and
- A contact name and telephone number to call for assistance or to express any unresolved concerns.

For all appeals, the Contractor must provide written notice of appeal resolution to the member, the member's representative, and/or the authorized provider requesting on behalf of the member or the provider filing the appeal.

For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice to the member, the member's representative, and/or the authorized provider requesting on behalf of the member.

Requirements for State Fair Hearings (42 CFR 438.408(f))
If the member has exhausted the Contractor level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the Contractor's notice of resolution.

The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.

Expedited Appeals Process: 438.410

General (42 CFR 438.410(a))

The Contractor must establish and maintain an expedited appeal process. The expedited review process is necessary when the CONTRACTOR determines, or the provider indicates, that the time required for a standards resolution could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function.

Punitive Action (42 CFR 438.410(b))

The Contractor shall not take punitive action against a provider acting on behalf of the member and with the member's written consent that requests an expedited resolution or supports a member's appeal.

Action following a denial of a Request for Expedited Resolution (42 CFR 438.410(c))

If the Contractor denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the timeframe for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The denial of a request for expedited resolution of an appeal does not constitute an Action and therefore does not require a Notice of Action.

Information about the grievance system to providers and subcontractors. 438.414

Information (42 CFR 438.414) (438.10 (g))

The Contractor must provide procedures and timeframes related to grievance, appeal, and fair hearings to all providers and subcontractors at the time they enter into a contract.

Record keeping and Reporting Requirements 438.416

The Contractor must maintain records of all grievances and appeals and resolutions. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be

retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

The Contractor shall provide DHH with a monthly Grievance and Appeal and Fair Hearing Log Report in a format prior approved by DHH of the grievances/appeals in accordance with the requirements outlined in this contract, to include, but not be limited to:

- The total number of grievances, appeals and State Fair Hearing Records held for the month broken out by members, providers filing on behalf of members, and providers;
- The status and resolution of all claims disputes;
- A listing of individual outstanding filed grievances and appeals with date of filing, description, current status, resolution, and resulting corrective action;
- Notices of State Fair Hearing to be held within the next thirty (30) days;
- Monthly number trends and types of grievances and appeals; and
- The number of grievances and appeals in which the Contractor did not meet timely disposition or resolution.
- Reports with redacted personally identifying information will be made available for public inspection upon request.

Continuation of benefits while the PIHP appeal and the State fair hearing are pending. 438.420

Terminology, Timely Filing and Continuation of Benefits (42 CFR 438.420(a), (b))

"Timely'' filing means filing on or before the later of the following:

- Within ten (10) days of the Contractor mailing the notice of action;
- By the intended effective date of the Contractor's proposed action, if less than thirty (30) days; or
- Within thirty (30) days.

The Contractor must continue the member's benefits if:

- The member, the member's representative, or the provider acting on behalf of the member and with the member's written consent, files the appeal timely;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits

Duration of Continued or Reinstated Benefits (42 CFR 438.420(c))

If, at the member's request, the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The member withdraws the appeal.
- Ten (10) days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits. Under such circumstances, benefits shall continue until a State Fair Hearing decision is reached.

- A State Fair Hearing Officer issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

Member Responsibility for Services Furnished (42 CFR 438.420(d))

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

Subcontractual Relationships and Delegation 438.230

Written Agreement (42 CFR 438.230 (a), (b))

- The Contractor is accountable for any functions and responsibilities that it delegates to any subcontractor as well as any payments to a subcontractor for services related to the contract.
- The Contractor shall be the single point of contact for all subcontract work.
- The Contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the Contractor will be satisfied by all subcontractors through the following:
    - The subcontractor(s) will provide a written commitment to accept all contract provisions.
    - The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract

Periodic Performance Review (42 CFR 438.230(b))

- The Contractor is responsible for periodic evaluation of subcontractor performance consistent with established state schedule, industry standards, or state laws and regulations.

Corrective Action Plan (42 CFR 438.230(b))

- The Contractor must ensure that identified deficiencies or areas for improvement are subject to corrective action.

Measurement and Improvement Standards

Practice Guidelines

Adoption (42 CFR 438.236(b))

The Contractor must adopts practice guidelines that meet the following requirements:

- Are adopted in consultation with a contracting healthcare professional.
- Are objective and based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field;
- Consider the needs of the members; and
- Are reviewed annually and updated periodically as appropriate.

The Contractor shall take steps to require adoption of the clinical practice guidelines by subcontracted providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers reviewed as part of the TRR plan are consistently in compliance with a performance rate of 80%, based on Contractor measurement findings. The Contractor should employ provider motivational incentive strategies, such as non-financial incentives, to improve compliance

Dissemination (42 CFR 438.236(c))
The Contractor shall develop and disseminate clinical practice guidelines to all providers as appropriate and, upon request, to members and potential members.

Application (42 CFR 438.236(d))
The Contractor will assure that decisions regarding utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Quality Assessment and Performance Improvement Program

Requirements (42 CFR 438.240(b))

- The Contractor shall maintain an internal QAPI program for all covered services that complies with state and federal standards specified in 42 CFR §438.200, the Medicaid State Plan and waiver applications relative to the CSoC, and any other requirements as issued by DHH.
- The Contractor shall have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to members with special healthcare needs.
- The Contractor shall collect data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural).
- The Contractor shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontracts, members and their families/caregivers, and providers and use the feedback and recommendations to improve performance

Performance Measures &/or Performance Improvement Projects (42 CFR 438.240) (b))

The State and CMS may specify PMs and topics for required Contractor performance improvement projects which must be achieved through ongoing measurements and intervention, significant improvement, sustained over time, clinically and non-clinically, with favorable effect on health outcomes and member satisfaction.

Under-utilization and Over-utilization (42 CFR 438.240(b)(3))

The Contractor is required to implement mechanisms to detect over and under-utilization of services.

The Contractor will develop a QAPI work plan and evaluation to address mechanism for detecting over and under-utilization.

Performance Measurement Requirements (42 CFR 438.240(b)(2) and 42 CFR 438.240(c

The Contractor shall have systems in place to measure and improve its performance in meeting the 1915(c) waiver assurances that are set forth in 42 CFR §441.301 and §441.302. The Contractor shall collect data, perform data analysis, and report data for the performance measures identified in the current 1915(c) application and in accordance with the specifications set forth within, as directed by DHH. In addition, the Contractor shall report data for the 1915(b)(3) population utilizing the specified 1915(c) measures. Data shall be available in both individual-level and aggregate form for all performance measures, as requested by DHH.

The Contractor shall collect data, perform data analysis, and report data for the performance measures identified in the CSoC QIS prepared by DHH and in accordance with the frequency identified in said document and the methodology approved by DHH

Requirements (42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1))

The Contractor shall establish and implement an ongoing program of PIP that focus on clinical and non-clinical performance measures as specified in 42 CFR 438.240.

The Contractor shall perform a minimum of one DHH-approved PIP. DHH may require up to two additional projects for a maximum of three projects

Reporting and Outcome (42 CFR 438.240(d)(2))

The QAPI committee shall submit an annual QAPI written evaluation to DHH that includes:

- A description of the ongoing and completed QAPI activities;
- Performance improvement project results;
- Performance measure results, including a summary to explain performance below the threshold/goal, remediation actions taken to improve performance if applicable, and trend analysis.
- Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care;
- Development of future work plans based on incorporation of previous year findings of the overall effectiveness of the QAPI program

State Review (42 CFR 438.240(e)(2))

The Contractor will be subject to annual review of the impact and effectiveness of their quality assessment and performance improvement program, including:

- Performance on the required standard measures.
- Results of PIPs

Health Information Systems 438.242

The Contractor's information system will support the QAPI process by collecting, analyzing, integrating, and reporting data necessary to DHH. All collected data shall be available to the state and upon request to CMS. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The system shall also collect data on member and provider characteristics and on services furnished to members and any other data as specified by the

state. The system shall ensure that data received from providers is accurate and complete by:

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

Remediation Actions

The premise behind the QIS process is one of continuous quality improvement. The Department of Health and Hospitals (DHH) strongly believes in working with the Contractor in a proactive manner to improve the quality of care received by Louisiana Medicaid and CHIP recipients; however, should the need arise, DHH may improve a system of graduated remediation which includes, but is not limited to:

- Administrative Action
- Corrective Action Plan (CAP)
- Monetary Penalties
- Sanctions
- Termination

Administrative Action

DHH may notify the Contractor through a written Notice to Cure when it is determined the Contractor is deficient or non-compliant with requirements of the contract. The Notice to Cure will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements

Corrective Action Plan

To correct or resolve any deficiency, DHH may require the Contractor to develop a CAP, which must include:

- A detailed explanation of the reasons for the cited deficiency;
- The Contractor's assessment of the cause;
- A specific proposal to remedy or resolve the deficiency;
- Detailed timelines and deliverables; and
- A Contractor lead or contact person for the CAP.

The CAP must be submitted by the deadline set forth in DHH request for a CAP. DHH will monitor the CAP to ensure necessary actions are taken by the Contractor to come into compliance with state and federal regulations.

Monetary Penalties

DHH may impose monetary penalties when the Contractor is out of compliance with the provisions of this contract, including, but not limited to, the following:

- Failure to meet the standards for encounter submissions and resubmissions as outlined in the contract and the failure to complete the scope of work for encounter data projects as outlined in this contract may subject the Contractor to penalties of between $500 and $250,000 depending on the severity of non-compliance with the established standards as determined by DHH;
- Failure to identify accountable person to absorb key vacant positions within Contractor system within fifteen (15) business days' results in penalty;

- Deliverables (including reports) required in the contract and any other ad hoc deliverables or report requested by DHH that are late, inaccurate, incomplete, inconsistent or submitted in a format not prior approved by DHH - $2,500 per calendar day per deliverable;
- Failure to meet any scope of work requirements as outlined in the contract may subject the Contractor to penalties of between $500 and $25,000 based on the severity as determined by DHH; and
- Late, incomplete or inaccurate submissions to DHH as outlined in the contract regarding actual and potential HIPAA noncompliance may subject the Contractor up to $2,500 in monetary penalties per day per violation until confirmation from DHH that the deliverable is satisfied.

In accordance, with Section 13410(d) of the HITECH Act and section 1176(a) of the Social Security Act, penalties for a covered entity or business associate violating HITECH range from $100 per violation to $1.5 million for all violations in a calendar year. Criminal penalties for the deliberate mistreatment of Protected Health Information (PHI) or failure of timely breach reporting may apply directly to any Contractor employee responsible for the offense. Penalties for individuals cannot exceed $250,000 and/or imprisonment not more than ten years.

- If the Contractor fails to comply with all applicable HIPAA requirements, the Contractor shall pay all fines or penalties imposed by the U.S. Department of Health and Human Services (HHS) under 45 CFR §160.404.
- The State may assess additional penalties for HIPAA noncompliance, failure to systemically correct HIPAA noncompliance, or failure to notify required parities (i.e., providers and/or members).

Sanctions

DHH may impose sanctions against the Contractor if it makes any determinations of the following non-exclusive actions/occurrences:

- The Contractor has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;
- The Contractor has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142 (Medicare-Medicaid anti-fraud and abuse amendments);
- The Contractor or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the contract with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the Contractor's member;
- The Contractor has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the state or the Secretary of the federal Department of Health and Human Services;
- The Contractor has engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made by DHH;
- The Contractor has rebated or accepted a fee or portion of fee or charge for a patient referral;
- The Contractor has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;
- The Contractor has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;
- The Contractor has failed to furnish any information requested by DHH regarding payments for providing goods or services; and
- The Contractor has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the contract.

- In the event that Contractor does not provide the services listed under this contract, or only provides a portion of the services, DHH will provide the Contractor fifteen (15) days' notice to cure or propose a Corrective Action Plan (CAP) and should Contractor not cure or propose an acceptable CAP within such fifteen (15) days, DHH reserves the right to withhold payments until such time as Contractor demonstrates that the services have been provided. However, such time period will be extended with agreement of all parties should the delay be attributable to causes beyond Contractor's reasonable control. As determined by DHH, DHH will not withhold payment if any relevant state agency fails to provide information necessary to cure or propose CAP.

Termination of Contract

In accordance with 42 CFR §438.708, DHH has the authority and may terminate the Contractor's contract and enroll that entity's members in another Contractor or provide their Medicaid benefits through other options, if DHH determines that the Contractor failed to do either of the following:

- Carry out substantive terms of its contract; or
- Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

DHH may terminate the contract immediately if it is determined that actions by the Contractor or its subcontractor(s) pose a serious threat to the health of members. If DHH determines the Contractor has become financially unstable, DHH will immediately terminate this contract upon written notice to the Contractor effective the close of business on the date specified.

Opportunities

The IMT will regularly review Contractor performance results and recommend corrective action/follow-up. This will be an important step to ensuring quality care and the implementation of QI activities. In subsequent versions and updates of the QIS, this Section will describe how benchmarks and goals have been established, various QI initiatives that DHH and the Contractor have engaged in over the past year, and progress in meeting objectives related to those initiatives.

Since this QIS is in the beginning stages of development and implementation, there will be modifications to the process at various steps of implementation. It will be important to continuously assess and revise the quality process to ensure the successful implementation of the QIS. In addition, performance measures and targets will also need to be continuously evaluated to ensure that the goals and measures meet appropriate populations and domains of care. The QIS will focus quality activities based on informed decisions from analyses of previous performance data and input from a variety of sources. As a result, sustained improvement is expected in subsequent years, brought forth by improvement initiatives, corrective action and systems changes that are implemented.