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State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

Quality Management Strategy for the Louisiana Coordinated Care Network (CCN)Program

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

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Medicaid Managed Care Program

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Quality Strategy Overview

The Louisiana Department of Health and Hospitals (DHH) is committed to "Making Medicaid Better" for Louisiana residents, providers and the State through an improved system of care supported by a strong quality improvement structure and processes. The Louisiana Quality Management Strategy (QMS) is a comprehensive plan incorporating monitoring, assessment, coordination and ongoing quality improvement processes to continually improve Medicaid/Children's Health Insurance Program (CHIP) care and services. The QMS is a vehicle to communicate the vision, goals and monitoring strategies addressing issues of health care quality, timely access and efficiency. The QMS also serves to meet the requirements specified by the Code of Federal Regulations (CFR) 438.202, which requires the development and maintenance of a Medicaid Quality Strategy.

The purposes of the strategy include:

- Articulating guiding principles for developing and implementing a quality strategy and prioritizing activities related to quality;
- Describing activities in the development, evaluation and updating of the strategy to reflect stakeholder input and continuous improvement;
- Providing structure and assignment of responsibilities for implementing the activities as described in the QMS;

- Identifying procedures for assessment of quality and appropriateness of care;
- Monitoring to ensure the services provided to Medicaid members conform to professionally recognized standards of practice, State and national rules and regulations; and
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, member and provider satisfaction with care and service and promotion of the patient-centered home model of care delivery.

The Louisiana DHH is transitioning from the current fee-for-service (FFS) delivery system (which rewards volume over value) to integrated care models that place accountability on the coordinated care network entity in DHH's Medicaid Coordinated Care Network Program.

DHH has defined its mission in the Coordinated Care Network Program as providing statewide leadership to most effectively utilize resources to promote the health and well-being of Louisianans in Prepaid Coordinated Care Network (CCN-P) and Shared Savings Coordinated Care Network (CCN-S) programs. The State intends to promote and further its mission by defining measurable objectives that will improve Medicaid and Medicaid-expansion CHIP enrolled individuals' access and satisfaction, maximize program efficiency, effectiveness and responsiveness and reduce operational and service costs.

1. Guiding Principles and Expected Outcomes

The guiding principles and expected outcomes have been developed throughout a lengthy Medicaid reform process. The Medicaid Reform Advisory Group, established in 2008, the Medicaid Advisory Committee and stakeholders were given an opportunity to review and provide feedback and comments through multiple public meetings held throughout the state, the Administrative Rulemaking process and postings on public websites. The guiding principles and expected outcomes of the Medicaid Coordinated Care Network Program include the following:

- Improved coordination of care;

- A patient-centered medical home for Medicaid recipients;
- Better health outcomes;
- Increased quality of care as measured by metrics, such as the Healthcare Effectiveness Data and Information Set (HEDIS);
- Greater emphasis on disease prevention and management of chronic conditions;
- Earlier diagnosis and treatment of acute and chronic illness;
- Improved access to essential specialty services;
- Outreach and education to promote healthy behaviors;
- Increased personal responsibility and self management;
- A reduction in the rate of avoidable hospital stays and readmissions;
- A decrease in fraud, abuse and wasteful spending;
- Greater accountability for the dollars spent;
- A more financially sustainable system; and
- Net savings to the State, when compared to the existing (FFS) Medicaid delivery system.

2. Quality Management Strategy Development

The Louisiana QMS is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess and continually improve the delivery of quality care and services to recipients in the CCN programs. The QMS provides a framework for the State of Louisiana (State) to communicate the vision, objectives and monitoring strategies for attaining quality, timely access and cost effectiveness. It encompasses an integrated collaborative approach with input from enrollees, advocacy groups, providers, governmental agencies and legislators. Unless otherwise specified, CCN encompasses both the Managed Care Organization (MCO) prepaid program (CCN–P) and the primary care case management with shared savings program (CCN-S). Those items that apply only to the CCN-P or CCN-S are duly noted.

The program planning and day-to-day operations of the CCN program are the responsibility of the Medicaid Managed Care Program (MMCP). The Medicaid Managed Care Quality Team (MMCQT) of DHH, which

includes the CCN Quality Manager, CCN Quality Strategy Manager, CCN Health Plan Managers, CCN subject matter experts as well as other DHH program areas as needed, is responsible for the development of the Louisiana QMS and for providing oversight of both the implementation and evaluation of the QMS. DHH's Medicaid Managed Care Leadership Team, which consists of the Medicaid Director, Medicaid Medical Director, DHH Undersecretary, DHH Chief of Staff, Medicaid Deputy Director for Managed Care and Medicaid Managed Care Program Manager(s), provides direction and oversight of the entire CCN program, including the QMS.

A. Enrollee and Advocacy Groups

DHH held nine Making Medicaid Better Forums across the State in November and December of 2010, hosted by the Secretary of the Department, to discuss plans for transforming Medicaid. These forums generated considerable press coverage. Stakeholders and other interested parties attended, asked questions and made suggestions about the Department's proposal for managing care for Medicaid enrollees. Some who provided input included Advocacy Center, Louisiana *Covering Kids & Families*, Louisiana Consumer Healthcare Coalition, Health Law Advocates of Louisiana, Families Helping Families, the Developmental Disabilities Council and the Children's Cabinet. The department also provided information to the State's four federally recognized Native American tribes in Louisiana: Chitimacha, Coushatta, Jena Band of Choctaw and Biloxi-Tunica. DHH provided videos, presentations and other resources from each forum through online web links for those who were unable to attend. The public was invited to submit comments or questions about the coordinated care plan through submission online to www.makingmedicaidbetter.com.

B. Providers

Louisiana Medicaid providers have been afforded the opportunity, both formally and informally, throughout the process to provide input into the design of the CCN Program. Presentations were made to and/or meetings held with provider associations, including Louisiana State Medical Society, Louisiana Chapter of the American Academy of Pediatricians, Medicine Louisiana, Louisiana Primary Care Association,

Louisiana Nurses Association, Louisiana Assembly on School Based Health Clinics, Louisiana Hospital Association, Metropolitan Hospital Association, Rural Hospital Coalition, Louisiana Office of Public Health, Louisiana State University Healthcare Services Division, Franciscan Missionaries of Our Lady, Christus Health System and Louisiana Independent Physician's Association.

C. Governmental Agencies and Legislatures

Hearings were held before legislative committees, including House Health and Welfare and Senate Health and Welfare. DHH conferred with the Department of Children and Families and the Office of Juvenile Justice, as well as sister agencies within DHH, including the Office for Citizens with Developmental Disabilities, the Office of Aging and Adult Services, the Office of Public Health and the Office of Behavioral Health.

D. Public Input

The State will place the 2011 QMS on the DHH website at www.makingmedicaidbetter.com**,** indicating a 30-day period for public input. Suggested revisions to the proposed quality strategy and improvement goals will be considered as appropriate prior to submission of the final draft to CMS. Following approval by DHH, any amendments to the quality strategy will be shared with the Centers for Medicare and Medicaid Services (CMS). The final QMS will also be published on the DHH website.

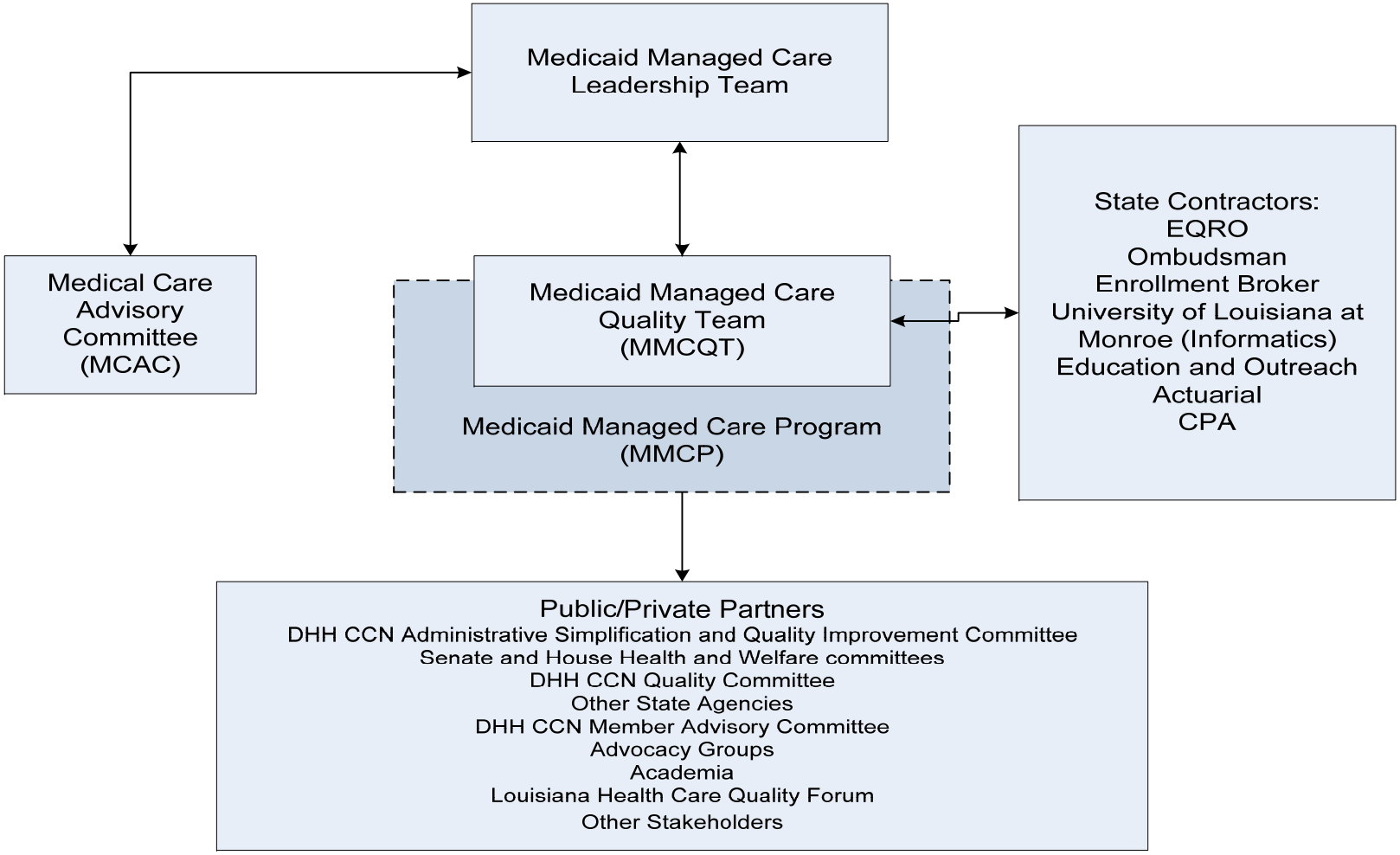
The QMS will be reviewed annually by DHH's MMCQT and the Medicaid Managed Care Leadership Team. The MMCQT will receive and address comments on the QMS from stakeholders, advocacy groups, consumer groups and others that review the document on an ongoing basis; public comments will be reviewed and updates/changes reflected in the next subsequent revision of the QMS. This process will include workgroups that will establish strategic partnerships among stakeholders to obtain input on the State's quality assessment and improvement strategies.

E. External Quality Review Report

The external quality review (EQR) technical report will provide detailed information regarding the regulatory compliance of Medicaid CCNs, as well as results of performance improvement projects (PIPs) and performance measures (PMs). Report results will provide information regarding the effectiveness of the CCN Program by identifying strengths and weaknesses and by providing information about problems or opportunities for improvement. This information will be utilized for modifications to the QMS and for the development and advancement of quality improvement projects.

3. Quality Management Strategy Implementation

The Medicaid Managed Care Quality Team is responsible for the implementation and evaluation of the Louisiana QMS and for the quality oversight process for the CCN programs. The Managed Care Leadership Team oversees various DHH staff and committees that track/trend and report information from the CCNs and provides recommendations for improvement and corrective actions. The MMCQT receives input on the implementation of the QMS. The DHH organization is depicted in the chart on the following page. The structure is developed to maximize integration, seek opportunities for collaboration and ensure a rigorous oversight process is in place.


Medicaid Managed Care Leadership Team
Medical Care Advisory Committee (MCAC)
Medicaid Managed Care Quality Team (MMCQT)
Medicaid Managed Care Program (MMCP)
State Contractors:
EQRO
Ombudsman
Enrollment Broker
University of Louisiana at Monroe (Informatics)
Education and Outreach
Actuarial
CPA
Public/Private Partners
DHH CCN Administrative Simplification and Quality Improvement Committee
Senate and House Health and Welfare committees
DHH CCN Quality Committee
Other State Agencies
DHH CCN Member Advisory Committee
Advocacy Groups
Academia
Louisiana Health Care Quality Forum
Other Stakeholders

The Medicaid Managed Care Program staff and/or the MMCQT receives and reviews all monitoring and quality reporting from CCNs and the External Quality Review Organization (EQRO). Findings from reporting will be presented to the appropriate monitor on the contractually required schedule. The MMCQT meetings will utilize quality improvement processes that include review of analysis of data and root cause analysis, all within the context of the "Plan, Do, Study, Act" cycle. The MMCQT will provide feedback to the CCNs throughout the process and specifically when corrective action will be requested. The MMCQT will also utilize extended workgroups of subject matter experts and stakeholders on an as needed basis to address specific topical issues.

The Managed Care Program Leadership Team or staff will hold weekly meetings with the CCNs during the implementation and immediate post-implementation of the program .The meetings are anticipated to transition to bi-weekly or monthly as the program matures. The Health Plan Managers will continue to have weekly calls with the CCN they are assigned for ongoing monitoring. There will be ongoing and *ad hoc* calls to provide a mechanism for dialogue on particular topics (i.e., information technology systems, third party liability, Patient Centered Medical Home, clinical practice standards), feedback and review of PIPs and identification of best practices.

The following table illustrates the Louisiana Quality Management Integrated Model roles and responsibilities.

Table 1: Quality Management Integrated Model: Oversight Roles and Responsibilities

Entities	Membership	Roles and Responsibilities
Coordinated Care Leadership Team	• DHH Chief of Staff • DHH Undersecretary • Medicaid Director • Medicaid Medical Director • Medicaid Deputy Director for	Direction and oversight of the CCN program, including the QMS Forum for input from key stakeholders into quality efforts and clinical management concerns. Forum for input on State policy for health care delivery to Medicaid enrollees, including the Medical Care Advisory

Entities	Membership	Roles and Responsibilities
	Managed Care • Medicaid Managed Care Program Manager	Committee (MCAC).
Medicaid Managed Care Quality Team	• CCN Quality Manager • CCN Quality Strategy Manager • CCN Health Plan Managers • CCN Subject Matter Experts (as needed)	Development and implementation of quality strategy Oversight and technical support Provide feedback for the: Establishment of priorities Identification, design, and implementation of quality reporting and monitoring Development of remediation strategies Reporting to Medical Director and Administrative Team (MDAT) Communication and support to stakeholders Provides Summary Reports and Dashboards to the Leadership Team
Quality Work Groups (QWG)	DHH and external Subject Matter Experts	Topic-specific quality issues Reporting to MMCQT

4. History of Managed Care in Louisiana

The Louisiana Medicaid program was implemented in 1966. Since that time, the program has experienced significant growth in the cost of providing basic medical services, as well as in the number of eligibility categories and the number and types of services offered. Enrollment in Medicaid continued to increase for State Fiscal Year 2010 to approximately 27% of Louisiana's population; payments were made on behalf of 1,303,984 recipients during this period.

CommunityCARE, Louisiana's primary care case management program (PCCM) was implemented in the 1990's. Operating under a waiver of Freedom of Choice under the authority of Section 1915(b)(1) of the Social Security Act and under a waiver of Statewideness (Section 1902(a)(1) of the Social Security Act, the program linked Medicaid recipients to a primary care physician in 20 rural parishes across the

State. Each primary care provider was reimbursed a per-member-per–month (PMPM) care management fee for care coordination and referrals.

Late in the 1990's, a managed care program was developed and a Request for Proposals (RFP) was released for bid. As a result of the low Medicaid reimbursement rates at the time, DHH was unable to contract with any health plan, and the program was never implemented.

Subsequently, the decision was made to expand CommunityCARE statewide, so that all enrollees would have a "medical home" for primary care services and the provision of care coordination and referrals to specialty services, and the phased-in expansion was completed in December of 2003. In 2006, a Section 1902(A)(1) State Plan Amendment was approved, and CommunityCARE has operated under State Plan rather than waiver authority since that time.

Effective January 1, 2011 DHH made changes to CommunityCARE to make part of the monthly care management fee to the approximately 850 primary care provider (PCP) sites contingent on meeting certain measures intended to improve quality: 1) attestation that the PCP will seek National Committee for Quality Assurance (NCQA) patient centered medical home recognition by October 1, 2011; 2)offer extended hours each week; 3)conduct early and periodic screening, diagnosis and treatment (EPSDT) screenings rather than contracting with another entity to do so; and 4) be in the lower quartiles for percentage of their CommunityCARE panel that had low level (99281, 99282) emergency room visits. An online tool was made available so that PCPs could determine the HEDIS scores for their panel on selected measures and compare that to not only the Louisiana statewide average, but the average in their Louisiana geographic region.

Despite expansion of the CommunityCARE program and the best efforts of many dedicated health care professionals, Louisiana leadership acknowledged the service gaps and system inadequacies of the existing FFS and basic PCCM systems of care. Louisiana continually places in the bottom tier of national health ratings.

While the basic PCCM model has achieved the goal of providing a primary care medical home for every enrollee, it has its limitations. Changes in enrollee behavior – a frequent theme among providers during the Medicaid reform summits held throughout the State – will require major rebalancing of the Medicaid and CHIP dollars spent, with greater investment in education and prevention. The basic PCCM model of Medicaid managed care does not address access to specialty care, as providers are still reimbursed according to the FFS rate schedule.

In December of 2008, the State submitted a request for a Section 1115 Research and Demonstration waiver to CMS. Louisiana Health First, in addition to introducing MCO and PCCM with shared savings models of coordinated care initially in four regions of the state, also included a coverage pilot for enrollees to 200% of the Federal Poverty Level (FPL) in the Lake Charles geographic region and would have expanded eligibility for parents to 50% of the FPL. The State did not pursue the waiver because of the economic downturn and ensuing availability of additional State dollars that would have been required for the eligibility expansions.

Although Medicaid reimburses for approximately 70% of all births in Louisiana, we have one of the highest rates of low birth weight babies and infant mortality. An increased focus on access to and coordination of medically necessary care – particularly in preventive, primary and specialty care – was identified as a vital component in reforming the Medicaid program and improving overall health outcomes for our Medicaid recipients.

Beginning in the fall of 2009, DHH initiated development of an improved statewide service delivery system for Medicaid and Medicaid-expansion CHIP through the development of the CCN Model. Input on the development and design of the program was gathered through a series of 35 meetings that included providers, hospitals, stakeholders, consumers, the general public and advocates from January 2010 through May 2011. DHH established a website (www.makingmedicaidbetter.com) to keep the public informed during the design of the CCN Program and provide current information on progress toward implementation. The website is a “one-stop shop” for

documents and information regarding CCNs and includes an online form that interested parties could submit electronically to provide suggestions or ask questions.

As a result of these efforts, a coordinated system of care was designed and included two Medicaid managed care models, which will be implemented simultaneously:

- The CCN-P is a traditional capitated MCO Medicaid managed care model in which entities establish a robust network of providers and receive a monthly payment (PMPM) for each enrollee to guarantee access to specified Medicaid State Plan services (referred to as core benefits and services) and care management services. The CCN-P will also provide additional services not included in the Medicaid State Plan and provider incentive programs to their network providers.

- The CCN-S is an enhanced PCCM Medicaid managed care model in which the entity receives a monthly per-member fee to provide enhanced PCCM services and PCP care management, with opportunities for that CCN entity to share in any cost savings realized from coordinating care with PCPs. Each CCN will be required to share a portion of savings with the PCPs. The amount and criteria for sharing savings with the PCPs will be determined by the CCN and approved by DHH.

An emergency rule creating the CCN model was published in the eight major daily newspapers in Louisiana in September 2010, but was withdrawn to obtain greater public input. After obtaining additional input from stakeholders, the Notice of Intent (NOI) was published on February 20, 2011 in the *Louisiana Registry*. The NOI outlined the:

- Participation criteria and responsibilities of each model of Coordinated Care Network in the Medicaid Managed Care Program;
- Medicaid recipient eligibility criteria for both mandatory and voluntary participation in the program;
- Enrollment and disenrollment criteria;

- Network access standards and guidelines;
- Benefits and services to be provided by each model;
- Reimbursement methodologies;
- CCN-S preprocessing and CCN-P prompt pay requirements;
- Enrollee grievance and appeals process for each model; and
- Sanctions if DHH determines the CCN is deficient or non-compliant with requirements specified by DHH.

Based on the feedback from providers and stakeholders, revisions were made, and a final rule was published on June 20, 2011.

After applying to CMS, DHH is anticipating receiving approval for CCN implementation under Section 1932 (1) (A) authority beginning January 1, 2012.

Rationale for Managed Care

According to a U.S. Government Spending Report, Louisiana government spent $7.4 billion in 2010 on health care.[1] Louisiana's Medicaid program currently provides coverage for approximately 25% of its population[2], reimburses for approximately 70% of the births annually and accounts for approximately 30% of the health care dollars spent in Louisiana. It has a huge impact on health outcomes, but squanders an opportunity for a positive impact. Louisiana has a fragmented Medicaid service delivery system that operates almost exclusively in a fee-for-service system environment that has little to no coordination, uneven quality of care, inequitable access to care and unpredictable costs. The Louisiana health care system was designed to provide episodic and acute care for heart attacks, pneumonia, appendicitis, stroke, flu, accidents and other conditions where people break, then mend.[3] The system was not

[1] U.S. Government Spending, http://usgovernmentspending.com/spend.php?span=usgs302&year=2010&view=1&expand=10&expandC=&units=b&fy=fy12&local=s&state=LA&pie=#usgs302.

[2] Medicaid Enrollment as a Percent of Total Population, 2007, Kaiser Family Foundation, Statehealthfacts.org, http://www.statehealthfacts.org/profileind.jsp?cmprgn=20&cat=4&rgn=38&ind=199&sub=52

[3] *A New Blueprint for Health Care Reform (an Executive Summary), Louisiana Business Group on Health, June, 2006.*

designed to promote and maintain health. According to the United Health Foundation's 2010 America's Health Rankings, Louisiana ranks 49th in the nation, based on 22 health determinants and health outcomes measures.[4] According to Annie E. Casey Foundation's 2010 KIDS COUNT Data Book, Louisiana ranks 49th in the nation, based on ten measures that profile the well-being of children.[5] Louisiana's challenge is twofold: designing and implementing a system of care that will be able to improve its health outcomes and move the State from the perpetual state of being at or near the bottom of the nation in health rankings, while dealing with a projected budget deficit and a mandate to downsize government.

A large body of evidence exists regarding the benefits of the Medicaid coordinated care model. The Lewin Group's report, *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies*, concludes, "...the studies present compelling evidence that Medicaid managed care programs can yield savings." Furthermore, both access and continuity of care are positively impacted. "In the overwhelming majority of cases, the state Medicaid managed care programs were found to have improved Medicaid beneficiaries' access to services and both the programs and individual managed care organizations (MCOs) have earned high satisfaction ratings from enrollees."[6] The savings estimates depend on the populations served, the comprehensiveness of services managed and degree to existing care coordination and range from 0.5% to 20%.

Based on extensive research and stakeholder input, DHH is transitioning Louisiana's Medicaid program to a managed care delivery system through the development of CCNs. DHH has carefully studied the experiences of other states, identifying best practices and practices to

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[4] *America's Health Rankings: Louisiana, 2010. United Health Foundation.* http://www.americashealthrankings.org/yearcompare/2009/2010/LA.aspx

[5] *KIdCount Data Center: Louisiana. Annie E. Casey Foundation, 2010.* http://datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=LA

[6] *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies*, Prepared for America's Health Insurance Plans, The Lewin Group, July 2004, Updated March 2009.

be avoided, and has consulted with experts and stakeholders across the State and the country. We have used those "lessons learned" to develop two models of managed care that represent the best evidenced practices for: 1) improving health outcomes for our population, 2) increasing access to quality care and 3) providing fiscal sustainability. The department is currently negotiating contracts for CCNs and related services. Initial operations are scheduled to begin in January 2012, with the phased statewide rollout to be completed by May of 2012.

The State intends to promote and further its mission by defining measurable results that will improve Medicaid and CHIP enrolled individuals' access and satisfaction, maximize program efficiency, effectiveness and responsiveness and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a patient-centered medical home for Medicaid and CHIP eligibles to promote continuity of care;
- Emphasize prevention and self-management to improve quality of life;
- Supply providers and members with evidence-based information and resources to support optimal health management; and
- Utilize data management and feedback to improve health outcomes for the State.

5. Goals and Objectives

The following goals and objectives reflect the State's priorities and areas of concern for the population covered by the CCNs. Quantifiable performance driven objectives and annual improvement targets for performance measures to demonstrate success or identify challenges in meeting intended outcomes will be determined by DHH in conjunction with the University of Louisiana at Monroe (ULM) in August 2012 through an analysis of calendar year 2011 baseline data.

Goal 1: To improve birth outcomes

Objectives:

- Increase the timeliness of early prenatal and postpartum care
- Decrease Cesarean rate for low-risk first-birth women
- Increase the number of eligible women who receive 17-OH progesterone during pregnancy, and decrease the percent of preterm births at fewer than 37 weeks
- Decrease percentage of live births weighing less than 2,500 grams

Goal 2: To improve accessibility to care and use of services for adults and children, with an emphasis on obtaining appropriate preventive and primary care.

Objectives:

- Increase access to preventive/ambulatory health services for adults
- Increase access to primary care practitioners for children and adolescents
- Increase timeliness of postpartum care
- Increase percentage of children who have at least six well visits within the first 15 months of life
- Increase percentage of children receiving well child visits in third, fourth , fifth and sixth years of life
- Increase percentage of adolescents receiving well visits
- Increase the frequency of ongoing prenatal care

Goal 3: Improve effectiveness and quality of care.

Objectives:

- Decrease Cesarean rate for low-risk first-birth women
- Increase the percentage of pregnant women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention
- Increase percentage of women receiving breast cancer screening
- Increase percentage of women receiving cervical cancer screening
- Increase immunization rates of children and adolescents
- Increase weight assessment and counseling for nutrition and physical activity in children and adolescents
- Increase appropriate testing for children with pharyngitis

- Increase follow-up care rates for children prescribed attention deficit hyperactivity disorder (ADHD) medication
- Increase HbA1C testing in all children and adolescents diagnosed with diabetes
- Decrease Otis Media Effusion rates for pediatric members
- Decrease pediatric central-line associated bloodstream infection
- Increase percentage of 5-56 year olds identified as having persistent asthma, who were appropriately prescribed asthma medication
- Increase controlling high blood pressure rates for members with hypertension
- Increase comprehensive diabetes screening rates for members with diabetes

Goal 4: Improve cost effectiveness through reducing potentially preventable hospital admissions and emergency room admissions.

Objectives:

- Decrease emergency room utilization rates
- Decrease adult asthma admission rate
- Decrease the annual number of asthma patients (one year old) with one asthma-related emergency room (ER) visit
- Decrease uncontrolled diabetes admission rates
- Decrease congestive heart failure (CHF) admission rates
- Decrease inpatient hospital (all plan) readmissions

Goal 5: Increase coordination and continuity of services.

Objectives:

- Increase the number of PCPs with NCQA Patient-Centered Medical Home Certification or Joint Commission Primary Care Medical Home Accreditation
- Increase adoption and utilization of electronic medical records
- Increase patient and provider satisfaction (as measured from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and provider surveys)

Goal 6: Increase transparency and accountability.

Objectives:

- Increase public reporting of performance data, including EQRO reports and findings
- Reduce fraud and abuse by providing and executing a clearly articulated policy of providing financial disincentives and sanctions as appropriate
- Ensure adherence to contract reporting and compliance

2

Assessment: Quality and Appropriateness of Care

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

The RFP, which is a part of the CCN contract, includes language requirements compliant with federal regulations.

A. 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". Medicaid enrollees, who are a member of any federally recognized American Indian or Alaskan Native tribe, may voluntarily elect to enroll in the CCN Program.

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. Louisiana has determined through ten years of collecting data via the Medicaid/CHIP application form on preferred spoken and written languages that Spanish and Vietnamese are the two most common foreign languages in which written materials are requested. The CCN contractors are required to ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of a CCN within the geographic service area (GSA). The State requires that the CCN and any contractors have translation services for those who speak **any** foreign language. The Enrollment Broker will provide multi-lingual interpreters and enrollment material in other alternate formats (large print, and/or Braille) when needed.

B. Communication with CCN

DHH contracts with an Enrollment Broker, who is responsible for the CCN Program's enrollment and disenrollment process for all Medicaid and CHIP potential enrollees and enrollees. The Enrollment Broker will make available to the CCN daily, via electronic media, updates on members newly enrolled into the CCN and will notify each CCN, at specified times each month, of the Medicaid eligibles that are enrolled, re-enrolled or disenrolled from their CCN for the following month. The Enrollment Broker will provide DHH a listing of current CCN members, via electronic media, on a monthly basis. The CCN or its administrator will be capable of uniquely identifying each member across multiple systems within its span of control. To facilitate care delivery appropriate to client needs, the enrollment file includes race/ethnicity, primary language spoken and selective health information. The CCN will utilize this information to provide interpreter services and facilitate enrollee needs in the context of their cultural and language requirements.

2. Mechanisms the State Uses to Identify Persons with Special Health Care Needs (SHCN) to CCNs

A member with SHCN is an individual of any age with a mental disability, physical disability or other circumstances that place his or her health

and ability to fully function in society at risk, requiring individualized health care requirements.

- The CCN will use historical claims data (if available) to identify members who meet CCN, DHH-approved guidelines for meeting SHCN criteria. The CCN must identify members with SHCN within 90 days of receiving the member's historical claims data. During the initial phase-in implementation of the CCN Program, DHH will extend the identification timeframe requirement to 180 days from the enrollment effective date.
- The PCP can identify members with SHCN at any time. An appropriate healthcare professional must conduct an assessment of those members within 90 days of identification. If an assessment determines a course of treatment or regular care monitoring, referral for case management will be provided.
- Members may also self identify as SHCN to either the Enrollment Broker or the CCN.

3. Clinical Practice Guidelines

The application of evidence-based clinical practice guidelines has proven to reduce variation in treatment, resulting in improved quality. The use of evidence-based clinical practice guidelines is expected, and guidelines must be based upon valid and reliable clinical evidence given the needs of the CCN enrollees. The guidelines can be adapted or adopted from national professional organizations or developed in a collaborative manner with community provider input. All practice guidelines must be adopted in consultation with contracting health care professionals and reviewed and updated in a clinically appropriate manner. The CCNs will coordinate the development of clinical practice guidelines with other CCNs to avoid providers receiving conflicting practice guidelines. Clinical guidelines are expected to represent the range of health care needs serviced by the CCN.

The CCN will use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions. The CCN will utilize evidence-based clinical guidelines and identify the source of the guidelines. These guidelines

and/or clinical care standards will be formally adopted by the CCN's Quality Assurance/Quality Improvement (QA/PI) Committee, including, but not limited to, those addressing:

- Asthma
- Diabetes
- Congestive heart failure
- NCQA Patient-Centered Medical Home Standards
- Joint Commission Primary Care Medical Home Accreditation
- Children's Health Insurance Program Reauthorization Act (CHIPRA) measures, including a focus on EPSDT services

Each CCN will disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines. CCNs will monitor adherence to practice guidelines by medical record reviews and performance measure outcomes and submit biannual performance measure outcome updates and quarterly medical record review data to DHH.

4. External Quality Review

The federal and State regulatory requirements and performance standards, as they apply to CCNs, will be evaluated annually by the State, in accordance with 42 CFR 438.204, by an independent EQRO, including review of the services covered under each CCN contract for timeliness, outcomes and accessibility, using definitions contained in 42 CFR 438.320.

The scope of the annual EQR conducted by the State for CCNs, 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 a CCN 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 CCN 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:

- Desk compliance review of all policies and procedures, program descriptions, committee minutes, manuals, handbooks and quality data
- On-site compliance visit conducted in the CCNs' Louisiana office(s) to review credentialing files, medical records, conduct staff interviews and provide feedback
- Validate PIPs required by the State
- Validate PMs required by the State
- Review each CCN's compliance with the State's standards for access, structure and operations, and quality measurement and improvement

Methods outlined in the EQR protocol include:

- Medical chart reviews
- CCN case management file reviews
- Provider surveys
- NCQA results
- Data analysis
- Administrative oversight and quality assessment and improvement review
- Focused studies of certain aspects of care

CMS optional EQRO activities that DHH has elected to have the EQRO perform include:

- Validation of encounter data
- Validate consumer and provider surveys on quality of care

- Provide written recommendations as to whether certain activities/expenditures meet the definition of "quality activities" for Medical Loss Ratio calculation purposes
- Provide technical assistance to CCNs through development of a Quality Companion Guide and annual CCN comparison study

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 CCN. 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 CCN.
- An assessment of the degree to which the CCN effectively addresses previous EQRO review recommendations. The EQRO does provide this information by:
  - Holding a review exit conference with the State and CCN administrative and clinical management staff to address findings and recommendations
  - Providing a written summary of reports, including findings and recommendations to the State and CCN

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 MMCP and ULM. Ongoing EQR status reports and final technical and project reports are communicated through the Making Medicaid Better website

(www.makingmedicaidbetter.com) and through report cards which will be formatted and disseminated to key stakeholders as well as posted on the website. 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 CCN, as well as results of PIPs and PMs. Report results provide information regarding the effectiveness of the quality management organization's program, identify strengths and weaknesses and provide information about problems or opportunities for improvement. This information is utilized for input into the QMS and for initiating and developing quality improvement projects.

If the CCN 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 MMCQT and/or the DHH Health Plan Managers provide ongoing monitoring of the corrective action plan.

5. Performance Measures and Performance Improvement Projects

CMS, in consultation with states and other stakeholders, may specify performance measures and topics for PIPs. As CMS has not yet specified a mandatory set of PMs or PIPs, the Managed Care Leadership Team in conjunction with input from the MMCQT, the Medical Care Advisory Committee and public and private partners, has identified a set of PMs and PIPs. These State-mandated measures and projects address a range of priority issues for the Medicaid and CHIP populations. In accordance with 42 CFR 438.240, the CCN must have an ongoing program of PIPs that focus on clinical and non-clinical areas. A PIP is intended to improve the care, services or enrollee outcomes in a focused area of study.

Final selection and approval of PIPs and PMs is the responsibility of the Medicaid Managed Care Leadership Team. State-specific PMs are reported by the CCN, and results are reviewed quarterly by the MMCQT, with final HEDIS results reviewed annually. Validation results of the PIPs are also reviewed by the MMCQT on an annual basis in conjunction with the EQRO compliance report results.

A. Louisiana Performance Measurement Set

The State requires the plans to collect data on patient outcome performance measures, as defined by HEDIS, CHIPRA Initial Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, CAHPS or otherwise defined by the State, and reports the results of the measures to the State annually. Because the majority of the Louisiana Medicaid enrollment is children and adolescents, the preponderance of the performance measures are related to child or adolescent health. The State may add or remove reporting requirements with 30 days advance notice. At a minimum, the following performance measures shall be measured by the CCN:

Table 2: Incentive-Based Performance Measures

Access and Availability of Care	Effectiveness of Care		Use of Services
$$ Adults' Access to Preventive/Ambulatory Health Services ***HEDIS*	**$$** Comprehensive Diabetes Care HbA1c ***HEDIS*	**$$** Chlamydia Screening in Women ***HEDIS/CHIPRA*	**$$** Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life ***HEDIS/CHIPRA*
			$$ Adolescent Well-Care Visits ***HEDIS/CHIPRA*

Table 3: Level I and Level II Performance Measures

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
	Childhood Immunization Status ***HEDIS/CHIPRA*		Well-Child Visits in the First 15 Months of Life ***HEDIS/CHIPRA*	Adult Asthma Admission Rate ***AHRQ*	CAHPS Health Plan Survey 4.0, Adult Version ***HEDIS*

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
Children and Adolescents Access to PCP *** HEDIS/CHIPRA*	Immunizations for Adolescents ***HEDIS/CHIPRA*	Percent of live births weighing less than 2,500 grams ***CHIPRA*	Ambulatory Care (ER Utilization) ***HEDIS*	CHF Admission Rate ***AHRQ*	CAHPS Health Plan Survey 4.0, Child Version, including Children With Chronic Conditions ***HEDIS/CHIPRA*
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) ***HEDIS/CHIPRA*	Cervical CA Screening ***HEDIS*	Cesarean Rate for Low-Risk First Birth Women ***CHIPRA*	Emergency Utilization-Avg # of ED visits per member per reporting period ***CHIPRA*	Uncontrolled Diabetes Admission Rate ***AHRQ*	Provider Satisfaction ***State*
	Breast CA Screening ***HEDIS/CHIPRA*	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/ Adolescents ***HEDIS/CHIPRA*	Annual # of asthma patients (1yr old) with 1 asthma related ER visit ***CHIPRA*	Plan all-cause readmissions *** HEDIS-adapted for Medicaid*	

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
	Controlling High Blood Pressure ***HEDIS*	Appropriate Testing for Children With Pharyngitis ***HEDIS/CHIPRA*	Frequency of Ongoing Prenatal care ***HEDIS/CHIPRA*		
	Follow-Up Care for Children Prescribed ADHD Medication ***HEDIS/CHIPRA*	Use of Medication for people with Asthma ***HEDIS/CHIPRA*			
	Otis Media Effusion ***CHIPRA*	Comprehensive Diabetes Care ***HEDIS*			
	Cholesterol management for patients with cardiovascular conditions	EPSDT screening rate ***CMS 416*			

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
	***HEDIS*				
	Pediatric central-line associated bloodstream infections ***CHIPRA*	Percent of pregnant women who are screened for tobacco usage and secondhand smoke exposure and are offered appropriate and individualized intervention ***State*			
		Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than			

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
		37 weeks and fewer than 32 weeks in those recipients ***State*			

B. Louisiana's 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 on 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 to screen and monitor care and services delivered.
- Implement system interventions to achieve improvement in quality.
- 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 special health care needs.
- 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 quality improvement 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 that each plan perform a minimum of two State-approved PIPs, one clinical and one non-clinical. The DHH required PIP during the first contract year is listed in Section 1 of Table 3 below. The CCN shall choose the second PIP from Section 2. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.

Table 3: Louisiana Performance Improvement Projects

Section 1	Specifications
Ambulatory Care Measure – Emergency Department Visit category - The number of emergency department visits per 1,000 member months	HEDIS
Section 2	**Specifications**
Cervical Cancer Screening - The percentage of women 24-64 years old in the denominator that received a cervical cancer screening	HEDIS
Breast Cancer Screening – The percentage of women 40-69 years old that received a breast cancer screening	HEDIS
Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life	HEDIS

Childhood Immunization Status (CIS) The percentage of children 2 years of age who had the appropriate immunizations by their second birthday (Combination 2)	HEDIS
Elective Delivery Prior to 39 completed weeks gestation	JCAHO
Cesarean Delivery Rate (nullipara)	JCAHO
Elective Delivery	JCAHO
Appropriate Use of Antenatal Steroids	JCAHO
Exclusive Breastfeeding at Hospital Discharge	JCAHO

Within three (3) months of the execution of the contract, the CCN shall submit, in writing, a description of each of their selected PIPs to the Department for approval. The detailed description shall include:

- An overview explaining how and why the project was selected, as well as its relevance to the CCN 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 EQRO validates the two PIPS per CCN each year. The EQRO report summarizes the findings for each CCN on the validated PIPs. It contains the analysis of findings, as well as recommendations for improvement.

6. State-specific Mandatory Performance Reporting

A. CCN Reporting Requirements

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.

The contractor may also be asked to produce additional ad-hoc reports in cooperation with other federal and/or State agencies upon request of the Department. 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.

The timeframe for reports due to the State are:

- Monthly reports will be due to the State on the fifth day of the following month
- Quarterly reports will be provided to the State 45-60 days following the end of each quarter
- Annual reports will be submitted to the State 90-180 days following the end of the calendar year

- Exceptions to this schedule will be identified with the applicable report
- Reports should be submitted electronically in a format approved by the State

1. Monthly Reports:

- Network provider and subcontractor registry
- Member services call center and unsuccessful new member contacts (annual summary)
- Provider call center (annual summary)
- Provider complaints and resolution
- Non-Medicaid enrolled providers (CCN-P)
- Grievance, appeal and fair hearing log report and redacted report (quarterly summary)
- Marketing activities update
- Claims payment accuracy report (CCN-P)
- Financial reporting (if requested by DHH)
- Denied claims (CCN-P)
- Federally qualified health centers/rural health clinics encounter file (CCN-P)
- Telephone and internet activity

2. Quarterly Reports

- PCP care management fee report (CCN-S)
- PCP linkage file
- CCN disenrollment
- Maximum number of members in each GSA
- EPSDT report (annual summary (CCN-P)
- Utilization management (UM) medical record reviews (annual summary)
- Fraud and abuse activity (annual summary)
- Chronic Care Management Program (CCMP) (annual summary)

- Grievance, appeal and fair hearing log report and redacted report (summary of monthly reports)
- Claims summary (CCN-P)
- Claims processing interest payments (CCN-P)
- Unaudited financial statements and financial reporting guide
- PCP utilization and profile (annual summary)
- Back-up file list
- Case management (annual summary)
- Member Advisory Council meeting minutes and correspondence

3. Semi-annual Reports

- Administrative performance reporting measures

4. Annual Reports

- Organizational chart and functional organizational chart
- Medical loss ratio (CCN-P)
- Patient-centered medical home implementation plan and recognition report
- Member services call center and unsuccessful new member contacts (summary of monthly reports)
- Provider call center (summary of monthly reports)
- Referral policies
- EPSDT report (summary of quarterly reports) (CCN-P)
- Medical record review
- Service area review of appointment availability (twenty-four hour access and availability survey) (CCN-P)
- UM medical record reviews (summary of quarterly reports)
- Fraud and abuse activity (summary of quarterly reports)
- CCMP report (annual summary of quarterly reports)
- CCMP predictive modeling specifications and program evaluation
- Emergency management plan certification
- Member satisfaction survey

- Provider satisfaction survey
- Network provider development and management plan
- Marketing activities annual review
- Third party liability collections (CCN-P)
- Audited financial statement
- Quality Assurance Program Initiative (QAPI) program description and QAPI plan
- Impact and effectiveness of QAPI plan
- PIP descriptions and outcomes
- Clinical and Administrative Level I and II performance measures
- PCP utilization and profile reports (summary of quarterly reports) (CCN-P)
- System refresh plan
- Electronic data processing audit
- Case management reports (summary of quarterly reports)
- Prior authorization and pre-certification summary
- SAS 70 report (CCN-P)
- Member Advisory Council plan
- Independent assessments of program impact, access, quality and cost-effectiveness

7. CMS Reporting Requirements

The State will prepare and submit annual reports summarizing progress toward QMS results. Progress toward goal achievement will be included, as available, from data and results reporting. Discussion of barriers and trends will be addressed.

Annual reports will be submitted 60 days after the close of the year.

The annual report will provide a detailed overall analysis and assessment of the effectiveness of the QMS strategy, including, but not limited to, the following:

- Quantifiable achievements;
- Data and numeric analysis;
- Discussion of variations from expected results;
- Barriers and obstacles encountered;
- Interventions planned to overcome barriers;
- How participant and system changes were improved as a result of QMS initiative results; and
- Best practices and lessons learned with resultant changes to the following year's strategy.

3

State 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 QMS document are incorporated in the CCN contract/RFP, which is in accordance with federal regulations.

The following table summarizes State-defined access standards.

Table 5: Appointment Standard

General	Specialty	Maternity
Emergency services – Available 24 hours a day, seven days a week	Consultation within one month of referral or as clinically indicated	Emergency services - Immediate
Urgent care - within 24 hours		Initial prenatal care – First trimester – within 14 days of first request
Non-urgent sick care within 72 hours or sooner if conditions deteriorates into urgent or emergency condition		Initial prenatal care – Second trimester – within seven calendar days of first request

General	Specialty	Maternity
Routine, non-urgent or preventive care visits – within six weeks of enrollee request		Initial prenatal care – Third trimester – within three calendar days of first request
		Initial high risk pregnancy - within three days of identification of high risk, or immediately if an emergency exists

1. Access Standards

Unless otherwise specified in the table below, CCN encompasses both the CCN-S and CCN-P programs. Those regulations that apply only to a CCN-S or CCN-P are duly noted.

Performance Standards
Delivery Network
Contracted network of appropriate providers (42 CFR 438.206(b)(1)) Each CCN must meet the following requirements. • Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each CCN must consider the anticipated Medicaid enrollment, the expected utilization of services, and take in to consideration the characteristics and health care needs of specific Medicaid populations enrolled. The CCN must also consider the numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services, the number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees. Distance, travel time, the means of transportation ordinarily used by Medicaid members, will be considered, and whether the location provides physical access for Medicaid members with disabilities. • The networks must be comprised of hospitals, physicians and specialists in sufficient numbers to make available all covered services in a timely manner. • The primary care network must have at least 1 full time equivalent PCP for every

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2,500 patients. Physicians with physician extenders (nurse practitioner/physician assistant, certified nurse midwife or OB/GYNs only) may increase the physician ration by 1,000 per extender. The maximum number of extenders shall not exceed two extenders per physician. • The CCN shall assure the availability of timely access to hospital care. Transport time will be usual and customary, not to exceed 30 miles, except in rural areas where distance may be greater. If greater, the standard shall be the community standard for accessing care. Exceptions must be justified, documented and submitted to DHH for approval. The CCN shall include, at a minimum, access to the following: o One (1) tertiary hospital in each parish in their service area, if a hospital is available, for the provision of inpatient and outpatient services, including emergency room services (free standing psychiatric hospitals and distinct part psychiatric hospitals do not meet this requirement): ▪ Essential hospital services for: ▪ Level III Obstetrical services; ▪ Level III Neonatal Intensive Care (NICU) services; ▪ Pediatric services; ▪ Trauma services; ▪ Burn services; and o One (1) tertiary hospital either recognized as a Children's Hospital by the National Association of Children's Hospitals and Related Institutions or a comparable facility with similar comprehensive levels of tertiary care pediatric services **Timely services for enrollees 438.6(k)(3)** • Each CCN-S must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.
Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2) • Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. • Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to members. • A women's health specialist may serve as a primary care provider.
Adequate and Timely Second Opinion (42 CFR 438.206(b)(3)) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5)) • If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the CCN must adequately and timely cover these

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services out of network for the enrollee for as long as the CCN is unable to provide them. • Requires out-of-network providers to coordinate with the CCN with respect to payment and ensures that cost to the enrollee 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)) Demonstrates that its providers are credentialed as required by § 438.214
Timely Access (42 CFR 438.206(c)(1)(i-vi)) • Each CCN-P must meet and require its providers to meet 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 identified in the chart at the beginning of the standards section. • 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. • Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. • Establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply. **Reasonable and Adequate Hours of Operation 438.6(k)(1)** • Each CCN-S must provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.
Cultural Considerations (42 CFR 438.206(c)(2)) • Each CCN participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. o The CCN is required to have available interpretive services for all languages other than English upon request. o The CCN will encourage and foster cultural competency in its employees.
Assurances of Adequate Capacity 438.207
Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c)) • Each CCN must give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. o *Nature of supporting documentation.* Each CCN must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the

Performance Standards

requirements below.
- Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of members for the service area.
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

- *Timing of documentation.* Each CCN must submit the required documentation, no less frequently than:
  - at the time it enters into a contract with the State or at any time there has been a significant change (as defined by the State) in the CCN operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the CCN.

Coordination and Continuity of Care 438.208

Except as specified below, the State must ensure through its contracts, that each CCN complies with the requirements of this section.

- **Exception for CCNs that serve dually eligible enrollees.**
  - For a CCN that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent that a CCN must meet the primary care coordination, identification, assessment, and treatment planning provisions of this section.
  - The State bases its determination on the services it requires the CCN to furnish to dually eligible enrollees.

Primary care and coordination of health care services for all CCN enrollees.
Each CCN must implement procedures to deliver primary care to and coordinate health care services for all CCN enrollees. These procedures must meet State requirements and must do the following:

- Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- Coordinate the services the CCN furnishes to the enrollee with the services the enrollee receives from any other CCN, PIHP, or PAHP.
- Share with other CCNs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.
- Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

CCN-P contract §6.33 and CCN-S contract §7.1.6
The CCN must maintain a case management program. The CCN will assure case managers initiate and maintain a member care/treatment plan that includes:

Performance Standards

- A thorough initial assessment including all domains of care with periodic updates, including enrollee strengths and barriers to care
- Short and long term goals that are developed in collaboration with the enrollee
- Periodic assessment of goal achievement and development of new goals
- Identification and documentation of coordination of care opportunities with all providers involved in the enrollee's care

Identification and Assessment (42 CFR 438.208(c)(1)(2))

- Identification. The State must implement mechanisms to identify persons with special health care needs to CCNs, as those persons are defined by the State. These identification mechanisms must:
    - Must be specified in the State's quality improvement strategy in § 438.202; and
    - May use State staff, the State's enrollment broker, or the State's CCNs.
- Assessment. Each CCN must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the CCN by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

Mechanisms for Members with Special Health Care Needs: Development of Treatment Plans (42 CFR 438.208(c)(3))

- Treatment plans. If the State requires CCNs to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—
    - Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
    - Approved by the CCN in a timely manner, if this approval is required by the CCN; and
    - In accord with any applicable State quality assurance and utilization review standards.

Mechanisms for Members with Special Health Care Needs: Direct Access to Specialists (42 CFR 438.208(c)(4))

- Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with § 438.208(c)(2)) to need a course of treatment or regular care monitoring, each CCN must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Coverage and Authorization of Services 438.210

Except as specified below, the State must ensure through its contracts, that each CCN complies with the requirements of this section.

- **Exception for CCNs that serve dually eligible enrollees.**
    - For a CCN that serves enrollees who are also enrolled in and receive Medicare

Performance Standards
benefits from a Medicare+Choice plan, the State determines to what extent that a CCN must meet the primary care coordination, identification, assessment, and treatment planning provisions of this section. o The State bases its determination on the services it requires the CCN to furnish to dually eligible enrollees. • CCNs and are required to provide for all medically necessary and appropriate Medicaid covered services, consistent with FFS Medicaid, in sufficient amount, scope, and duration to achieve the purpose of the service(s) and, may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. • The CCN may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. And specify what constitutes "medically necessary services" in a manner that: o is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and o addresses the extent to which the CCN is responsible for covering services related to the following: ▪ the prevention, diagnosis, and treatment of 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)) • For the processing of requests for initial and continuing authorizations of services, each contract must require: o That the CCN and its subcontractors have in place, and follow, written policies and procedures. o That the CCN ▪ Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and ▪ Consult with the requesting provider when appropriate. • That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
Notice of Adverse Action (42 CFR 438.210(c)) Each contract must provide for the CCN to notify the requesting provider, and give the enrollee written notice of any decision by the CCN to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.
Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e)

Performance Standards

- Each CCN contract must provide for the following decisions and notices:
  - *Standard authorization decisions*. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:
    - The enrollee, of the provider, requests extension: or
    - The CCN justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
  - *Expedited authorization decisions.* For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

  - The CCN may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the CCN justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

- Compensation for utilization management activities. Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Emergency and Post–Stabilization Care Service (42 CFR 438.114)

The CCNs will comply with the definitions used in this section:

- *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- *Emergency services* means covered inpatient or outpatient services that are:
  - Furnished by a provider qualified to furnish emergency services.
  - Needed to evaluate or stabilize an emergency medical condition.
- *Post-stabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

Performance Standards

- The CCN must cover Post Stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor‘s provider network if any of the following circumstances exist:
  - The Post stabilization Services were pre-approved by the Contractor;
  - The Post Stabilization Services were not pre-approved by the Contractor because the Contractor did not respond to the Provider‘s request for these Post stabilization services within one (1) hour of the request;
  - The Post stabilization services were not pre-approved by the Contractor because the Contractor could not be reached by the provider to request pre-approval for these post stabilization services; or
  - The Contractors representative and the treating physician cannot reach an agreement concerning the member‘s care and a Contracting physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in
    42 CFR 422.113 (C) (3) is met.

- The CCN may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

- The CCN may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee’s primary care provider, CCN, or applicable State entity of the enrollee’s screening and treatment within 10 calendar days of presentation for emergency services.

- An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

- The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities responsible for coverage and payment.

2. Structure and Operations

Structure and Operations Performance Standards
Provider Selection
Selection and Retention (42 CFR 438.214(a), (b)(2)) • The State must ensure, through its contracts, that each CCN implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section. • Each CCN must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the CCN.
Nondiscrimination (42 CFR 438.214(c)) (42 CFR 438.12(a)) • CCN provider selection policies and procedures, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. • If a CCN declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. • Contractors must also have a written appeals process providers will use to challenge any denial of credentialing resulting from this process.
(42 CFR 438.12 (b)(1)) The CCN will not be required to contract with providers beyond the number necessary to meet the needs of the members.
(42 CFR 438.12(b)(2)) The CCN may use different reimbursement amounts for different specialties or for different practitioners in the same specialty.
(42 CFR 438.12(b)(3)) The CCN is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.
Excluded Providers (42 CFR 438.214(d)) The CCN 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)) Each CCN must comply with any additional requirements established by the State. • The CCN is required to contract with the Louisiana State University safety net, Office of Public Health, School Based Health Clinics.
Confidentiality 438.224
Confidentiality requirements consistent with (42 CFR 438.224), (45 CFR parts 160 and 164) • The CCN, including all providers, physicians' practitioners, suppliers, etc., shall have in place policies and procedures to maintain the confidentiality of all-medical records and assure that all records and their use meet all HIPAA requirements. • The State is not required to obtain written approval from an enrollee before requesting

the enrollee's record from the primary care provider or any other provider and shall be afforded access within thirty 30 calendar days to all enrollee's medical records whether electronic or paper.

- The Contractor shall upon the written request of the enrollee, guardian or legally authorized representative of an enrollee, furnish a copy of the medical records of the enrollee's health history and treatment rendered. Such record shall be furnished within a reasonable time of the receipt of the written request.

- When an enrollee changes primary care providers, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request.

- The CCN must have written policies and procedures for maintaining the confidentiality of data, including medical records/enrollee information and adolescent/STD appointment records.

- Access to all individually identifiable information relating to Medicaid enrollees that is obtained by the CCN shall be limited by the CCN to persons or agencies that require the information in order to perform their duties in accordance with this contract, and to such others as may be authorized by the State in accordance with applicable law.

- The CCN must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of the contract.

Enrollment and Disenrollment

Enrollment and Disenrollment (42 CFR 438.226)
Each CCN 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)

- All CCN contracts must have written policies that specify the reasons for which the CCN may request a transfer of an enrollee and reasons a transfer may not be requested. The CCN may not initiate transfers because of a medical diagnosis or health status of an enrollee, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (unless the enrollee's continued enrollment in the CCN seriously impairs the entity's ability to furnish services to either this enrollee or other enrollees), or non-compliance related to diagnosis, an enrollee's attempt to exercise his or her rights under the grievance system, or based on the demands of an enrollee to seek referrals to specialists or for information regarding their medical condition system.

- The CCN will identify methods to assure the State that it does not request transfer for reasons not covered by contract.

Disenrollment requested by the member

- The CCN must provide that an enrollee may request to transfer for cause at any time and without cause, at the following times:
  - During the 90 days following the enrollee's initial enrollment date or State notice of enrollment date, whichever is later
  - At least once every 12 months thereafter
  - Upon automatic reenrollment
  - Upon State imposed sanctions per 438.702(a) (3)

Procedures for Disenrollment

- The CCN may initiate transfers for valid reasons including:
  - Persistent and documented refusals of the enrollee to comply with contractor requirements that are consistent with State and Federal laws and regulations.
  - Misuse of the system, abuse or threatening conduct by the enrollee.
  - Deliberate falsification of application or enrollment materials by the enrollee.
- The CCN must have attempted through education and case management to resolve any difficulty leading to a request for transfer unless the enrollee has demonstrated abusive or threatening behavior.
- The state may require that the enrollee seek redress through the CCN grievance system before making a determination on the enrollee's request. If the grievance process is used, it must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month in which the request was made.

Enrollment and disenrollment 438.6(k)(2) and (k)(5)

- Each CCN-S must restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.
- Each CCN-S must provide that enrollees have the right to disenroll from their primary care case manager in accordance with 438.56(c).

Prohibited discrimination 438.6(k)(4)

- Each CCN-S must prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

Grievance Systems 438.228

Grievance Systems (42 CFR 438.228(a))

The CCN 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 CCN 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 of, or payment for, medical assistance.
- An "action" shall be defined as:
  - Denial or limited authorization of a requested service, including the type or level of service;
  - Reduction, suspension, or termination of a previously authorized service;
  - 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;
- For a resident of a rural area with only one Contractor, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services out of network.

- *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 CCN level and access to the State fair hearing process.

General Requirements 438.402

The Grievance System (42 CFR 438.402 (a))

- Each CCN 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))

- An enrollee may file a grievance or a CCN level appeal and may request a State Fair Hearing. A provider or the enrollee's legal representative acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State Fair Hearing on behalf of an enrollee.

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

- An enrollee may file a grievance either orally or in writing. A provider may file a grievance as the State permits the provider to act as the enrollee's authorized representative.
- An enrollee or the provider may file an appeal; and request a Fair Hearing within a timeframe that may be no less than 20 days and not exceed 90 days from the date on the Contractors notice of action.

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

- An enrollee may file a grievance orally or in writing and, either with the State or with the CCN and unless he or she requests expedited resolution must follow an oral filing with a written, signed, appeal.

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

42 CFR 438.228, 431.206(b) and 431.210:

The CCN has delegated responsibility for State Fair Hearing notices.

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

- The CCN is required to provide information on State Fair Hearing procedures including, but not limited to the enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing. Additionally, the State fair hearing description must be included in enrollee and provider information.

- The CCN must give the enrollee written notice of any action to include but not limited to, service authorizations, within the timeframes for each type of action.

- CCNs are responsible to ensure timely notification of an enrollee of his/her right to use the State administrative grievance process.

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

- The CCN is required to make written information available in prevalent non-English languages in its particular service areas. In Louisiana, Spanish and Vietnamese are currently the prevalent non-English languages.

- Inform the enrollee about rights as an enrollee of CCN services; this will include informing the enrollee both orally and in a clearly written format in the enrollee's own language about both the CCN and State grievance and appeal procedures; if the enrollee has an auditory and/or visual impairment, reasonable accommodations must be made to assure that the enrollee is informed and understands his/her rights

Format:

- The CCN must produce written materials including notice of actions and must meet the language and format requirements to ensure ease of understanding. Information must be available in alternative formats, must be available and in an appropriate manner.

- The CCN is required to notify all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

Notice of Adverse Action Content (42 CFR 438.404(b)) (42 CFR 431.206(b) and 431.210)

- The notice must explain the action the CCN or its sub-contractor has taken or intends to take. The reason for the action and the enrollee's or provider's right to file an appeal with the CCN or to request a state fair hearing. Procedures for exercising the enrollee's right to appeal or grieve. Circumstances under which an expedited resolution is available and how to request it, and the enrollee's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the cost of these services.

- The CCN will also inform enrollees that:
  - the enrollee may represent himself or use legal counsel, a relative, a friend, or other spokesman
  - the specific regulations that support, or the change in Federal or State law that requires, the action
  - an explanation of the enrollee's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.)

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

Termination, Suspension, or Reduction of Services

- The CCN is required to give at least 10 days notice before the date of action when the action is termination, suspension, or reduction of previously authorized Medicaid-covered services:

- Except If probable enrollee fraud has been verified, then 5 days
- By the date of the action for:
  - The death of an enrollee;
  - A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services;
  - The enrollee's admission to an institution where he is not longer eligible for services;
  - The enrollee's address is unknown and the mail directed to him has no forwarding address;
  - The enrollee has accepted Medicaid services by another local jurisdiction;
  - The enrollee's physician prescribes the change in level of medical care;
  - An adverse determination made with regard to the preadmission screening requirements for Nursing Facility admissions on or after January 1, 1989; or
  - The safety or health of individuals in the facility would be endangered, the enrollee's health improves sufficiently to allow more immediate transfer or discharge, an immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the NF for 30 days.

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

Authorization Decisions

- The CCN 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 CCN 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 CCN 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 CCN 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 CCN grievance and appeals process must be approved by the State. The appeals process shall consist of an informal internal review by the CCN (Stage 1 appeal) and a

formal internal review by the CCN (Stage 2 appeal). The enrollee always has the right to appeal to the DHH, whether or not they have filed an appeal with the CCN.

- The CCN 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 CCN will acknowledge the receipt of each grievance and appeal within 5 days of receipt.

- Ensure that 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 an appeal of a denial that is based upon lack of medical necessity or grievance resolution regarding denial of expedited resolution of an appeal or a grievance or appeal that involves clinical issues are health care professionals who have the appropriate clinical expertise as determined by the State, in treating the members condition or disease.

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 CCN 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 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 CCN 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 90 calendar days from the day the CCN receives the appeal.

- For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the CCN receives the appeal and for expedited resolution of an appeal and notice to affected parties, the timeframe is no longer than 3 working days after the CCN receives the appeal.

- The CCN may extend the timeframes by up to 14 days if the enrollee requests an extension, or the CCN shows there is need for additional information and that the delay is in the enrollee's interest. For an extension not at the enrollee's request, the CCN must give the enrollee written notice of the reason for the delay. If the CCN extends the timeframes, it must for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

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

The CCN must follow State defined requirements for notification of an enrollee of the disposition of an appeal.

- The CCN will provide written notice of disposition of grievances and appeals and for expedited resolution; the CCN must also make reasonable efforts to provide oral notice.

- The CCN must provide written notice of disposition, which must include the results date of appeal resolution. And for decisions not wholly in the enrollee's favor:
  - The right to request a State fair hearing
  - How to request a State fair hearing
  - The right to continue to receive benefits pending a hearing
  - How to request the continuation of benefits
  - If the CCN action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

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

- Ensure that the CCN appeal system cannot be prerequisite to, nor a replacement for, the enrollee's right to appeal to the DHH and request a fair hearing in accordance with 42CFR 431, Subpart E. The enrollee always has the right to appeal to the DHH, whether or not they have filed for an appeal with the CCN.

- The entire Appeal/Fair Hearing process must be accomplished within the specified 90-day period from notice of "action".

- The parties to the State fair hearing include the CCN as well as the enrollee and his or her representative of a deceased enrollee's estate.

Expedited Appeals Process: 438.410

General (42 CFR 438.410(a))

The CCN must establish and maintain an expedited appeal process. The expedited review process is necessary when the CCN determines, or the provider indicates, that the time

required for a standards resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

Punitive Action (42 CFR 438.410(b))

The CCN must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

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

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

- transfer the appeal to the standard timeframe of no longer than 45 calendar days from the day the CCN received the appeal, with a possible 14-day extension.
- give the enrollee prompt oral notice of the denial then written notice within two calendar days. This decision does not constitute an action therefore can be grieved but not appealed.

Information about the grievance system to providers and subcontractors. 438.414

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

- The CCN 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.
- Information must include the right to a State fair hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.
- The right to file grievances and appeals with requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process including the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing. The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

Record keeping and Reporting Requirements 438.416

- The CCN is required to maintain records of grievances and appeals. Those records will include, at a minimum a log of all grievances/appeals whether verbal or written. The log should include enrollee identifying information, a statement of the appeal and resolution, if affected. Log data should be analyzed monthly to identify trends and/or

patterns for administrative use and review

- Logs must always be available for State and CMS review.

Continuation of benefits while the CCN 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 that the appeal is filed on or before the later of the following:
  - Within 10 days of the CCN mailing the notice of action, or
  - The intended effective date of the CCN proposed action;
- The CCN must continue the enrollee's benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services and the authorization period has not expired.
- The enrollee requests extension of benefits.

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

- If the CCN continues or reinstates benefits, they will be continued until the enrollee withdraws the appeal or does not request a fair hearing within 10 days from when the CCN mails an adverse enrollee decision. Benefits will also continue until a State fair hearing decision adverse to the enrollee is made or the authorization expires or authorization service limits are met.

- Information regarding continuance of benefits must be included in the "Notice of Action" letters to the enrollee's representative.

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

The CCN may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with (431.230 (b)), if the final resolution of the appeal upholds the CCN action.

Effectuation of Reversed Appeal Resolutions 438.424

Effectuation when Services were not Furnished (42 CFR 438. 424(a))
The CCN must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires if the CCN or State fair hearing officer reverses the decision to deny, limit, or delay services.

Effectuation when Services were Furnished (42 CFR 438. 424(b))
The CCN or the State must pay for disputed services in accordance with State policy and regulation if the CCN or State fair hearing officer reverses the decision to deny authorized services and the enrollee received the disputed services while the appeal was pending.

Subcontractual Relationships and Delegation 438.230

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

- The CCN 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 CCN shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the CCN or subcontractor(s) that, in the opinion of the CCN, may result in litigation related in any way to the contract with the State.

- The CCN is responsible to maintain a written agreement between the entity and subcontractor that specifies the delegated scope of work, and report responsibilities including revocation of agreement.

- Before any delegation, each Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

Periodic Performance Review (42 CFR 438.230(b))

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

Corrective Action Plan (42 CFR 438.230(b))

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

3. Quality Assessment and Performance Improvement

Measurement and Improvement Performance Standards

Practice Guidelines

Adoption (42 CFR 438.236(b))

- Each CCN adopts practice guidelines that meet the following requirements:
  - Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
  - Consider the needs of the CCN enrollees.
  - Are adopted in consultation with contracting health care professionals.
  - Are reviewed and updated periodically as appropriate.

Dissemination (42 CFR 438.236(c))

Each CCN will disseminate the guidelines and new technologies to all affected providers, and upon request to members, potential members, consumer advocates.

Application (42 CFR 438.236(d))

Each CCN 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))

- Each CCN is required to have an ongoing quality assessment and performance improvement program consistent with contractual obligations, State and Federal requirements and accreditation guidelines for the services it furnishes to its enrollees.

- Contractors must survey their enrollees on at least an annual basis to determine satisfaction with Contractor's services.

- Each CCN must also have a quality management plan for the upcoming year that is consistent with the State Quality Strategy. This plan must describe the program's scope; objectives and all planned projects, activities, and focused studies for the upcoming year. The plan must also describe monitoring of previously identified issues including tracking of issues over time. A timetable must be included, which clearly identifies target dates for implementation and completion of all phases of activities. This plan must be approved by DHH prior to implementation.

- The program at a minimum must outline the administrative and organizational structures and design of the quality management program.

- Describe methodologies and mechanisms for objective and systematic monitoring of access to care and services provided to members.

Measurement and Improvement Performance Standards

- Describe mechanisms to ensure that findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported to individuals within the organization for use in conjunction with other related activities.

- Describe methodologies and mechanisms for tracking issues over time with an emphasis on improving health outcomes; such mechanisms should be developed in accordance with the guidelines of the *Guide to Clinical Preventive Services* (Report of the U.S. Preventive Services Task Force), the EPSDT guidelines, or other criteria based on scientifically or clinically validated analysis.

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

The State and CMS may specify performance measures and topics for required CCN 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))

- Each CCN is required to implement mechanisms to detect over- and under-utilization of services.

- Each CCN will develop a Utilization Management Plan and annual work plan.

- Describe methodologies and mechanisms for monitoring and auditing provider performance, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communication of all findings to providers.

Quality and Appropriateness of Care (42 CFR 438.240(b)(4))

The CCN is required to have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees with particular emphasis on children with special health care needs.

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

- The CCN is responsible to provide:
  - A full description of how they will address the clinical program initiatives as specified by the State for the Medicaid population.
  - Ongoing reports quarterly, semi-annually, and annually as specified in the reporting section. Additional reports as determined necessary by the State for quality assurance and improvement activities.

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

The CCN is responsible to conduct performance improvement projects, approved by the State that will achieve demonstrable and sustained improvement over time incorporating

Measurement and Improvement Performance Standards

performance improvement standards of measurement, including objective quality indicators, implementation, and evaluation and planning.

Performance Measurement (42 CFR 438.204(c))

The CCN must measure and report to the State its performance using standard measures required by the State including those developed in consultation with States and other relevant stakeholders. (42 CFR 438.3204c and 438.240(a)(2). The CCN must submit data specified by the State to enable the State to measure the CCN's performance.

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

The CCN is required to report the status and results of each project to the State upon request and annually as requested for the EQR process and must produce new information on quality of care every year.

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

- The CCN 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 Performance Improvement Projects.

Information requirements

Member Information as required by 42 CFR 438.10 (42 CFR 438.218) The State assumes the following responsibilities:

- 438.10(a) The State defines the following terms compliant with the 438.10(a), "enrollee" means a Medicaid recipient who is currently enrolled in a CCN. A "potential enrollee" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific CCN.

- 438.10(b)(1)(d)(1)(i) The State assures the CCN that the enrollment broker will provide all enrollment-related notices, informational materials, and instructional materials to enrollees/potential enrollees in a manner and format that may be easily understood.

- Choice Counseling - Mechanism. The state has delegated to the enrollment broker the responsibility to help enrollees and potential enrollees understand the State's managed care program.

- 42 CFR 438.10(c)(3)&(4)&(5) The State assures that the enrollment broker makes its written information available in the prevalent non-English languages in its particular service area, as specified by the State in the contract. The State assures that the enrollment broker makes oral interpretation services available free of charge to each potential enrollee and enrollee. The enrollment broker must notify enrollees:

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- that oral interpretation is available for any language
- that written information is available in prevalent languages
- how to access the interpretation services and written information

- 42 CFR 438.10(d)(1)(ii)&(d)(2) Information - Alternative formats. The State is responsible to assure written material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

- 42 CFR 438.10 (e)(f) Information - Potential enrollees and enrollee non-covered services. The State assures through its contract with the enrollment broker that each CCN is informed of any services available under the State plan and not covered by the CCN contractor. That the enrollment broker shall make available to potential enrollees and new enrollees, information in a written and prominent manner of any benefits to which the enrollee may be entitled but which are not made available to the enrollee by the entity. Such information shall include information on where and how such enrollee may access benefits not made available to the enrollee through the CCN.

- 42 CFR 438.10(e)(1) & (e)(2) 42 CFR 438.102(c) Information – Potential Enrollees.

The State delegates through the contract to the enrollment broker who must provide the information of this Section to each potential enrollee as follows:

- At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
- Within a timeframe that enables the potential enrollee to use the information in choosing among available CCNs.

The information for potential enrollees must include the following:

- General information about:
  - the basic features of managed care
  - which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program
  - CCN responsibilities for coordination of enrollee care.

- Information specific to each CCN program operating in the potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
  - benefits covered
  - cost sharing, if any
  - service area
  - names, locations, telephone numbers of, and non-English language spoken by

Measurement and Improvement Performance Standards

current contracted providers, and including identification of providers that are not accepting new patients. For CCNs this includes at minimum information on primary care physicians, specialists, hospitals.

- The State will provide, through the enrollment broker, information to enrollees indicating benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. This includes counseling or referral services that the CCN does not cover because of moral or religious objections.

- 42 CFR 438.10(f)(3) Information - Enrollees. The State assures the enrollment broker provides information to each enrollee as follows:
  - Notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.
  - Notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll for cause.
  - Notify all enrollees of their right to request and obtain information at least once a year.

CCN Requirements

Information Requirements (42 CFR 438.10 (a), (b))

- 438.10(a) the CCN will be compliant with how the State defines the following terms compliant with 438.10(a), "enrollee" means a Medicaid recipient who is currently enrolled in a CCN in a given managed care program. A "potential enrollee" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific CCN.

- The CCN is required to meet the following State standards regarding information:
  - (b) The CCN must provide all informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
  - (3) The CCN will have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.
  - (c) (1) Language. The CCN must comply with the State's definition of prevalent non-English languages spoken by enrollees and potential enrollees throughout the State.
  - (c) (3) The CCN will make available written information in each prevalent non-English language in its service area.
  - (c), (4) The CCN will make oral interpretation services available and free of charge to each potential enrollee and enrollee in its service area for Spanish and Vietnamese at all times and for all languages not just those identified by the State as prevalent upon request.
  - (c)(5) (i)&(ii) The CCN will notify its enrollees that:

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  - that oral interpretation is available for any language and written information is available in prevalent languages
  - how to access those services
- (d) Format. (1),(i)&(ii) The State expects the CCN will assure that written material uses:
  - (i) easily understood language and format at no more than a 6.9 grade reading level.
  - (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- (2) The CCN will inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
- (f)(4)The CCN will provide enrollees with written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f) (6) of the Section and if applicable, paragraphs (g) and (h) of this Section, at least 14 days before the intended effective date of the change.
- (f)(5) The CCN must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from the provider.

- 438.10(f)(6)(i) The CCN will provide the following information to enrollees;
  - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, include identification of providers that are not accepting new patients. For the CCN this includes, at a minimum, information on primary care physicians, specialists, hospitals, nursing facilities and HCBS providers.

- 438.10(f)(6)(ii) restrictions on the enrollee's freedom of choice among network providers.

- 438.10(f)(6)(iii) enrollee rights consistent with 438.100.

- 438.10(f)(6)(iv) information on grievance and fair hearing procedures, and for CCN members, the information specified in §438.10(g)(1), and for PAHP members, the information specified in §438.10(h)(1).

- 438.10(f)(6)(v) describing the amount, duration, and scope of benefits, and in sufficient detail to assure the enrollees understand entitled benefits.

- 438.10(f)(6)(vi) the procedures for obtaining benefits and authorizations for services.

- 438.10(f)(6)(vii) the extent and how enrollees may obtain benefits, including family planning services from out of network providers, and

Measurement and Improvement Performance Standards
• 438.10(f)(6)(viii) the extent of and how after hour emergency services are provided including: o 438.10(f)(6)(viii), (a) what constitutes and emergency providing definitions consistent with 438.114 o 438.10(viii)(b) a prior authorization is not required for Emergency Services o 438.10(viii)(c) the process and procedures for obtaining emergency services, including use of the 911- telephone system o 438.10(viii)(d) locations of emergency setting and locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract o 438.10(viii)(e) informing enrollees that they have a right to access the nearest emergency facility without regard to contracting status • 438.10(6) (ix) The CCN will provide information to enrollees congruent with 422.113; • 438.10 (6)(x) policy on referral for specialty care and other benefits not furnished by the enrollee's primary care provider. • 438.10(6)(xi) cost sharing if any.
Information to Members 42 CFR 438.10 G • The CCN will provide enrollees with information about State fair hearing, the right to a hearing and the method for obtaining a hearing. Information to enrollees will include: o the rules that govern representation at the hearing o the right to file grievances and appeals, requirements and timeframes for filing a grievance or appeal and the availability of assistance in the filing process o the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone o the fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee o any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service o advance directives, as set forth in §438.6(i) (2) • Additional information that is available upon request, including the following: o Information on the structure and operation of the CCN. o Physician incentive plans as set forth in §438.6(h) of this chapter.

4. Intermediate Sanctions

The premise behind the QMS process is one of continuous quality improvement. Louisiana strongly believes in working with its CCNs in a proactive manner to improve the quality of care received by Louisiana Medicaid and CHIP recipients. However, should the need arise, part of Louisiana's quality management process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. The sanctions for the CCN-P plan meet the federal requirements of 43 CFR Subpart I, as well as Louisiana's State requirements for sanctions and terminations. Because the CCN-S plan is not a MCO, Louisiana has chosen to implement State requirements for sanctions and conditions for termination. The sanctions for the CCN-S plans differ as they do not need to meet the federal requirements of 42 CFR Part 438 Subpart 1.

DHH will have the right to impose penalties and sanctions, arrange for temporary management, as specified below, or immediately terminate the CCN contract under conditions specified below.

Whenever the State determines that the CCN is failing to provide one or more core benefits and services, it may authorize members to obtain the covered service from another source. In the event that DHH determines that the CCN failed to maintain an adequate network of mandatory contracted provider types, a monetary penalty per incident may be assessed.

The State may impose sanctions against a CCN if the CCN:

- Fails substantially to provide medically necessary services that the CCN is required to provide, under law or under its contract with DHH, to a member covered under the contract;
- Imposes on members' premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid CCN program;
- Acts to discriminate against or among members on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to re-enroll a member, except for reasons in Section 11.12.2 or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or to DHH;
- Misrepresents or falsifies information that it furnishes to a member, potential member or health care provider;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR. 422.208 and 422.210;
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information;
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations;
- Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations.

Where these violations are documented, the State will require a corrective action plan (CAP) be developed and submitted within five (5) calendar days of the date of receipt of notification of the violation or non-compliance from DHH. Upon approval by DHH, the CCN must

implement the initial or revised CAP within the timeframes specified by the Department.

If the CAP is not successful, intermediate sanctions will be applied. The State may also choose to:

- Impose civil monetary penalties in the specified amounts
- Appoint temporary management for the CCN as provided in 42 CFR 438.706
- Grant members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll
- Suspend all new enrollments, including automatic assignment, after the effective date of the sanction
- Suspend payment for members enrolled after the effective date of the sanction and until CMS or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur
- Apply additional sanctions allowed under the State statute or regulations that addresses areas of non-compliance

The following factors will be considered in determining sanction(s) to be imposed:

- Seriousness of the offense(s);
- Patient quality of care issues;
- Failure to perform administrative functions;
- Extent of violations, history of prior violations, prior imposition of sanctions;
- Prior provision of provider education, provider willingness to obey program rules;
- Whether a lesser sanction will be sufficient to remedy the problem; and
- Actions taken or recommended by peer review groups or licensing boards.

If DHH determines that the CCN is out of compliance with the contract, DHH may suspend the CCN's enrollment of new members under the contract after notification by DHH. When exercising this option, DHH will notify the CCN in writing of its intent to suspend new enrollment prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DHH. The Louisiana Medicaid Director may require the CCN contractor to correct any deficiencies which served as the basis for the suspension as a condition of reinstatement of enrollment activities.

The State may not terminate a contract with a CCN, unless the CCN is provided with a hearing prior to the termination. However, if the State determines that actions by the CCN or its subcontractor(s) pose a serious threat to the health of members enrolled in the CCN, DHH may terminate the contract immediately. In this event, the CCN will be given an opportunity to enroll in another CCN or move to fee-for-service.

Temporary management will be imposed by DHH if it finds that:

- There is continued egregious behavior by the CCN, including, but not limited to, behavior that is described in 42 CFR 438.700 or that is contrary to any requirement of sections 1903(m) and 1932 of the Social Security Act; or
- There is substantial risk to member's health; or
- The sanction is necessary to ensure the health of the CCN's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the CCN.

The State may not delay imposition of temporary management to provide a hearing before imposing temporary management. In addition, the State will not terminate temporary management until it determines that the CCN can ensure that the sanctioned behavior will not recur.

DHH's election to appoint temporary management shall not act as an implied waiver of DHH's right to terminate the contract, suspend

enrollment or to pursue any other remedy available to DHH under the contract.

4

Quality Assessment and Performance Improvement

1. Monitoring Mechanisms – State Monitoring and Evaluation

As required by CFR 438.204(b)(3), Louisiana will regularly monitor and evaluate the CCN's compliance with the standards. The State will engage in a variety of methods to ensure that the CCN develops and implements a quality plan that meets the expectations communicated through the QMS, the managed care contract and compliance requirements specified within Balanced Budget Act (BBA) regulations. Monitoring mechanisms for required standards are summarized in the table below.

Table 6: Monitoring activities

Monitoring Mechanism	Member CAHPS Survey	Provider Survey	Grievance & Appeal Log	EQRO Report	CNN Performance Measures (HEDIS, CHIPRA, AHRQ)	CNN Validated PIPs	CNN Reporting (Clinical, Operations & Financial	Admini-strative PMs
Access to Care Standards								
Availability of Services	X		X	X			X	X
Network Adequacy	X		X	X	X		X	X
Coordination and Continuity of Care	X	X	X	X			X	
Special Health Care Needs	X			X	X		X	
Coverage and Authorization of Services	X	X	X	X			X	X
Structure and Operational Standards								
Provider Selection and Credentialing		X		X			X	

Monitoring Mechanism	Member CAHPS Survey	Provider Survey	Grievance & Appeal Log	EQRO Report	CNN Performance Measures (HEDIS, CHIPRA, AHRQ)	CNN Validated PIPs	CNN Reporting (Clinical, Operations & Financial	Admini-strative PMs
Confidentiality	X		X	X			X	

Enrollment and Disenrollment				X			X	
Grievance Systems	X		X	X			X	
Sub-contractual Relationships & Delegation				X			X	
Quality Measurement and Performance Improvement Standards								
Practice Guidelines				X	X	X	X	
QAPI				X		X	X	
Health Information Systems				X	X	X		
PIPS				X	X	X	X	X
PMs				X			X	

Each CCN establishes a QAPI that specifies regular scheduled meetings and mechanisms to review and analyze data and reports, identify root causes, barriers and improvement interventions. CCNs must submit reports to DHH as referenced in Chapter 2 of this Quality Strategy. The Medicaid Managed Care Quality Team reviews and monitors reports submitted from the CCNs. The Organization Chart and Table 1 in the Quality Management Strategy Implementation section of Chapter 1 depict the monitoring and oversight process. If the MMCQT and/or the Health Plan Managers determines that the CCN's quality performance is not acceptable, the CCN will be required to submit a CAP. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the provisions of sanctions set forth in the CCN contract and may immediately terminate all new enrollment activities and automatic assignments.

Monitoring mechanisms will include:

1. Member and Provider Satisfaction Survey
    a) Member Satisfaction: In order to assess the quality and appropriateness of care to all Medicaid enrollees, Louisiana is requiring that CCNs administer a CAHPS survey designed to measure client experience and satisfaction with the CCN. Each CCN must enter into an agreement with a vendor that is verified by NCQA to perform CAHPS surveys. The survey is administered annually to a statistically valid random sample of clients who are enrolled in health plans at the time of the survey. The surveys will provide valid and reliable data for individual plan results in a specific service delivery area. Analyses can also provide statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. The CAHPS Health Plan Survey 4.0 for Medicaid Enrollees will be used and includes:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Customer Service
- Global Ratings

Monitored by: Medicaid Managed Care Quality Team.

Frequency: Annually

b) Provider Satisfaction Surveys will be administered by the CCN annually to assess satisfaction with provider enrollment, provider communications, provider education, provider complaints, claims processing (CCN-P), utilizations review processes and support toward patient-centered medical home (PCMH) implementation. Feedback from the surveys will enable plans and the State to identify provider issues and areas for improvement.

Monitored by: Medicaid Managed Care Quality Team.

Frequency: Annually

2. Grievance/Appeal Logs

State review of CCN-established process for maintaining records of all grievances and appeals, with sufficient data to identify the person who makes the grievance or appeal and the date of receipt, nature, resolution and date of resolution for each grievance and appeal. Copies of grievances and appeals redacted of PHI will be posted on the www.makingmedicaidbetter.com website.

Review of grievance and appeal data and information is also used to assess quality and utilization of care and services. Results from ongoing analysis are applied to evaluation of compliance with quality

expectations. CCNs are subject to monetary penalties if more than 10% of their adverse decisions are reversed at the State Fair Hearing level. State Fair Hearings are being contracted to the Division of Administrative Law.

Monitored by: Medicaid Managed Care Quality Team.

Frequency: Monthly and quarterly summary

3. EQRO

Following a competitive procurement, the State has contracted with Island Pro Review Organization for EQRO functions. Results of the EQR ensured the State's compliance with BBA regulations and assessed the CCNs for compliance with requirements as addressed in the QMS and the CCN contract. The EQRO monitors availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special health care needs, coverage and authorization of services, emergency and post stabilization services, provider selection/credentialing, enrollment and disenrollment, grievance systems, practice guidelines, quality assessment and performance improvement program, health information systems, performance improvement projects and performance measurement. The EQRO report also includes evaluation of how effectively the CCNs address improvement recommendations from the EQRO the prior year.

In accordance with 42 CFR 438.228 (b), during the EQR process, a random sampling of grievance and appeal charts will be selected to monitor the CCNs and their providers and subcontractors to ensure they are providing timely notification to enrollees of the delegated State Fair Hearing.

Monitored By: Medicaid Managed Care Quality Team.

Frequency: Annually

4. CNN PMs
   The EQRO conducts validation of PMs selected by the State and reported during the preceding twelve months. Results of the PM validation process will be compliant and demonstrate actual results on an annual basis, progressing toward achievement of the stated goal for that measure.

   Monitored by: Medicaid Managed Care Quality Team.

   Frequency: Quarterly and annually, based on contract requirements for specific performance standard

5. CNN PIPs
   The EQRO conducts validation of PIPs. PIPs will be analyzed, compared to expected outcomes, and determinations to continue or adjust will be based upon results.

   Monitored by: Medicaid Managed Care Quality Team.

   Frequency: Annually

6. CCN Reporting:
   DHH monitors CCNs through reporting that includes incentive based measures as identified in Chapter 2, section 5 and contractually required reporting as identified in Chapter 2, section 6 of this Quality Management Strategy. This includes an annual review and approval of the plan's written quality management plans and the annual evaluation of effectiveness.

   Review and analysis of CCN required reports provides the opportunity for tracking and trending of progress on an ongoing basis. The CCN is required to submit a variety of reports on a monthly, quarterly or annual basis. These reports allow the State to provide oversight for quality measures and identify trends early. Corrective action plans are required for measures that fall below minimum performance benchmarks.

Monitored by: Medicaid Managed Care Quality Team.

Frequency: Weekly, monthly, quarterly and annual reports as defined in the CCN-S and CCN-P Reporting Requirements Section

7. Administrative System Performance Measures
   CCNs collect and report on the Administrative System Performance Measure outcomes in order to monitor and evaluate the successful implementation of the CCN program.

   Monitored By: Medicaid Managed Care Quality Team.

   Frequency: Monthly

2. Non-Duplication Strategy

Non-duplication regulation provides states the option to use information from a private accreditation review to avoid duplication with the review of select standards required under 42 CFR 438.204(g). The standards that may be considered for this deemed compliance, as referenced in 438.204(g), are those listed in Subpart D of the regulations for access to care, structure and operations and measurement and improvement. However, Louisiana Department of Insurance does not currently require that managed care plans licensed and doing business in Louisiana become accredited by a national accrediting organization; therefore, DHH will not implement a non-duplication strategy at this time. DHH will require contracted CCNs to become accredited as early as possible.

3. Health Information Technology

Each CCN must maintain a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this Section. The system must provide information on areas, including, but not limited to, utilization, grievances and appeals and disenrollments for other than loss of Medicaid eligibility.

At a minimum, each CCN is required to comply with the following:

i. Collect data on member and provider characteristics, as specified by the Department, and on services furnished to members through an encounter data system or other methods as specified by the Department.
ii. Ensure that data received from providers is accurate and complete by:
    a. Verifying the accuracy and timeliness of reported data;
    b. Screening the data for completeness, logic and consistency; and
    c. Collecting service information in standardized formats to the extent feasible and appropriate.
iii. Make all collected data available to the Department and upon request to CMS.

5

Improvement and Interventions

1. Performance Measure Validation

Performance measures provide information regarding directions and trends in the aspects of care and service being measured. The information is used to focus and identify future quality activities and direct interventions to improve quality of care and services. Performance measures are tracked and trended, and information will be used to focus future quality activities. CCNs performing poorly in certain performance measures are expected to conduct root cause analyses and identify appropriate interventions for improvement. The EQRO will validate and make improvement recommendations for seven PMs each year for each CCN. The seven PMs will include five incentive-based measures and two additional measures, one of which will be calculated using administrative methodology, and the other will be calculated using hybrid methodology.

2. Performance Improvement Projects

A PIP is intended to improve the care, services or member outcomes. DHH selects PIP topics to be performed by the CCNs, and the CCNs also select topics individually that address specific areas of concern.

The general expectations for PIPs include:

Year 1: PIP development process, appropriate study topic, clearly defined study question and indicators, correctly identified study population, baseline results, valid sampling methods, accurate and complete data collection, analyses identify interventions for the re-measurement year;

Year 2: Interventions implemented and results reported;

Year 3: Re-measurement and ongoing improvement with adjustment in interventions, as appropriate;

Year 4: Re-measurement demonstrating ongoing improvement or sustainability of results, and future years to be determined based on results, sustainability and member needs.

Each CCN will perform a minimum of two State-approved PIPs, one clinical and one non-clinical. The DHH-required PIP during the first contract year is "Ambulatory Care Measure – Emergency Department Visit category - The number of emergency department visits per 1,000 member months". The CCN shall choose the second PIP from eligible projects as listed in Chapter 2, Table 3, Section 2 of this Quality Strategy. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.

The EQRO will validate two PIPs in the first year, with the possibility of an additional PIP each year to reach a maximum of four PIPs per CCN each year. Results are expected to demonstrate progress toward achievement of the identified goal.

3. Public Reporting

DHH has established the website www.makingmedicaidbetter.com to post public reporting regarding quality activities and progress toward quality goals. Posting may include results of performance measure reporting displayed by CCN in a simple and understandable format for review by consumers, providers and stakeholders.

4. Collaboration

Louisiana will implement and maintain a robust quality improvement framework, including a Medicaid Managed Care Quality Team. Ongoing collaboration will involve the Louisiana Healthcare Quality Forum, the Medicaid Advisory Committee, the Birth Outcomes Initiative and the DHH/CCN Member Advisory Committee, which will be established. This framework and these committees will support the quality improvement

process, provide resources to implement quality improvement initiatives and monitor performance against quality strategy goals and objectives.

One statewide collaborative effort is the Birth Outcomes Initiative (BOI). This priority initiative is focused on developing a plan for increased coordination of resources and targeted investments that can make positive impacts on birth outcome measures such as preterm birth, low birth weight, and hospital-based maternity care. Along with these targeted investments, greater access to quality care and improved data collection have the potential to lead to significant cost savings in Medicaid and across DHH while creating a healthier generation of Louisianans. Participation on the BOI team includes 80 quality and measurement experts, hospitals and health systems leaders, health plans, clinicians, consumers and community partners committed to improving the health of women and infants in Louisiana. Team members represent medical professional organizations, hospitals, providers, consumers and community partners.

Performance measures provide information regarding directions and trends in the aspects of care being measured. This information is used to focus and identify future quality activities and direct interventions for existing quality activities. The Quality Strategy Committee will assist plans in analyzing HEDIS, CAHPS and utilization data. Topic-specific workgroups will be used to help with particular quality issues. For measures progressing toward or meeting goals, ongoing measurement with barrier analysis may continue. Measures meeting goals for at least two consecutive cycles may continue to be measured or, to ensure improvement is maintained, may be placed on an annual re-measurement cycle. For measures demonstrating consistent lack of progress or goal achievement, corrective action plans may be required to assist the contractor in meeting measurement expected results. The corrective action must demonstrate appropriate actions to positively impact measurement results.

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

5. Pay-for-Performance

DHH does plan to implement a Pay for Performance Program. This financial incentive program will be aligned with the goals of the CCN Program in that it is a program that will reward CCNs for gains in members' access to health care services and improved program quality and efficiency of the CCN's delivery system through provider practice improvements.

For CCN-Ps, incentives will be based on a CCN's performance measure outcomes for each calendar year. A maximum of 2.5% (0.5% for each of the five (5) incentive-based measures) may be deducted for up to twelve months, effective October following the measurement year if results fall below the benchmarks established by DHH.

CCN-S plans are eligible for shared savings after actual medical costs and the enhanced PCCM fees are reconciled against the established per capita prepaid benchmarks. The amount of shared savings for which the CCN is eligible is also contingent upon quality performance measure outcomes. A maximum of 100% eligible (20% for each of the five (5) incentive-based performance measures) savings payout will be contingent upon the CCN's performance measure outcomes each calendar year or otherwise specified by DHH. All incentive based and Level I performance measures that fall below performance standards will require a CAP.

The incentive-based measures selected by DHH, and presented in the following table, are also found in Chapter 2 of the QMS and Appendix J of the CCN RFP. DHH will finalize benchmarks for these measures following review of 2011 HEDIS results.

TABLE 7: Incentive Measures

Access and Availability of Care	Effectiveness of Care		Use of Services
$$ Adults' Access to Preventive/Ambulatory Health Services ***HEDIS*	**$$** Comprehensive Diabetes Care HbA1c ***HEDIS*	**$$** Chlamydia Screening in Women ***HEDIS/CHIPRA*	**$$** Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life ***HEDIS/CHIPRA*
			$$ Adolescent Well-Care Visits ***HEDIS/CHIPRA*

In addition, during the first two years of implementation of the CCN-S Program, distribution of any savings achieved will be contingent upon the CCN-S meeting established contract reporting requirements, benchmarks for specified clinical performance measures and/or compliance with the Contract, as determined by DHH and approved by CMS.

A. Intermediate Sanctions and Corrective Action Plans

To be effective, the quality improvement process should be one of continuous quality improvement. The State will work with the CCNs in a proactive manner to improve quality of care provided by the plan to members. Intermediate sanctions and CAPs will be used only when other strategies and tools have been considered and have not been effective.

6

Strategy Review and Effectiveness

The QMS will be reviewed, at least annually, by the MMCQT and Medicaid Managed Care Leadership Team and revised based on results of analyses. The MMCQT presents quality data to the Medicaid Managed Care Leadership team regularly to evaluate progress toward goals and objectives based on results of quality performance measures. Performance measure results, along with dialogue through stakeholders regarding current issues and barriers to access and quality, inform decisions regarding the upcoming year's goals and measures. Annually, measures are assessed to determine if the measures will continue or new measures should be added. Criteria used to make decisions regarding measure recommendations are based on the following criteria:

- Relevance: Measures must be relevant to health and delivery system problems experienced by 1–18 year old children.
- Scientific soundness: Measures must be based on evidence produced through strong research.
- Feasibility: Measures initially must meet at least one of three requirements:
  - Be retrievable through routinely collected administrative data
  - Be collected via survey of enrollees or their caretakers
  - Be collected via a medical record review

Additional considerations for decisions regarding quality measures and initiatives include technical aspects, such as:

- The measure has been in operation for a sufficient period of time to demonstrate effectiveness (i.e., usually three years);
- Has demonstrated success that has been documented through tangible results;
- Consistency with current policy and evidence-based practice. The QMS provides a mechanism for DHH to think strategically about the flow of quality data and the management of intervention activities. This QMS guides monitoring and intervention activities for implementation by all plans and programs.

7

Opportunities

Drafting the QMS has allowed MMCP staff to think strategically about means for monitoring the quality of care provided to enrollees, the flow of quality data and the management of intervention activities. This QMS will guide monitoring and performance improvement activities for all CCN plans and programs. The QMS will be reviewed, at least annually, by the Medicaid Managed Care Leadership Team and revised based on analysis results.

The Medicaid Managed Care Quality Team will regularly review CCN performance results and recommend corrective action/follow-up. This will be an important step to ensuring quality care and the implementation of quality improvement activities. In subsequent versions and updates of the QMS, this Section will describe how benchmarks and goals have been established, various quality improvement initiatives that DHH and the CCNs have engaged in over the past year and progress in meeting objectives related to those initiatives. The MMCP staff will present annual summary report findings to the MMCQT to solicit feedback regarding the quality strategy, historical and current HEDIS, CAHPS and utilization data.

Since this QMS 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 QMS. 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 QMS 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.

Appendix A

Definition of Medical Necessity

Medically necessary services are defined as those health care services that, in accordance with accepted standards of practice, are deemed reasonably necessary by the Medicaid program to diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, have resulted or will result in a handicap, physical deformity or malfunction and no equally effective, more conservative or less costly course of treatment is available or suitable for the recipient who has requested the service.

Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

Services that are experimental, investigational, non-FDA approved, cosmetic or intended primarily for the convenience of the recipient are specifically excluded from Medicaid coverage and will be deemed NOT medically necessary.

The fact that a provider has prescribed, recommended or approved health care services does not mean that such services are medically necessary or a covered Medicaid service.

The Department defines the terms "investigational" or "experimental" as the use of a service, procedure or supply that is not recognized as standard medical care for the condition, disease, illness or injury being treated. A

service, procedure or supply includes, but is not limited to, the diagnostic service, treatment, facility, equipment, drug or device.

A service is considered investigational (experimental) if any of the following criteria are met:

1. The services, procedures or supplies requiring federal or other governmental body approval, such as drugs and devices, do not have unrestricted market approval from the Food and Drug Administration or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
2. There is insufficient or inconclusive medical and scientific evidence to permit the Department (or agent) to evaluate the therapeutic value of the service, procedure or supply.
3. There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the service, procedure or supply has a beneficial effect on health outcomes.
4. The service, procedure or supply under consideration is not as beneficial as any established alternatives.
5. There is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the service, procedure or supply has a beneficial effect on health outcomes or is as beneficial as any established alternatives.
6. Investigational (experimental) services do not meet the criteria for "medically necessary services" because these services are not standard medical practice.

The Medicaid Director is granted final authority to make exceptions regarding coverage based on case by case circumstances at his/her discretion.

Appendix B

Acronyms (Amend)

Adjusted Clinical Groups (ACGs)
Balanced Budget Act of 1997 (BBA)
Centers for Medicare and Medicaid Services (CMS)
Children with Special Health Care Needs (CSHCN)
Congestive Heart Failure (CHF)
Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Controlled Dangerous Substances (CDS)
Department of Health and Social Services (DHSS)
Division of Social Services (DSS)
Drug Enforcement Agency (DEA)
Early and Periodic Screening Diagnosis and Treatment (EPSDT)
Emergency Room (ER)
External Quality Review (EQR)
External Quality Review Organization (EQRO)
Federal Poverty Limit (FPL)
Fee-for-Service (FFS)
First State Health Plan (FSHP)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Health Risk Assessment (HRA)
Managed Care Organizations (MCOs)
Management Information System (MIS)
Medical Management Information System (MMIS)
Medicaid Director and Administrative Team (MDAT)
National Committee for Quality Assurance (NCQA)
Office of Management and Budget (OMB)

Performance Improvement Projects (PIPs)
Performance Measures (PMs)
Pharmacy Benefits Manager (PBM)
Physician Service Network (CCN)
Prepaid Ambulatory Health Plans (PAHP)
Prepaid Inpatient Health Plans (PIHP)
Primary Care Case Management (CCN)
Primary Care Physician (PCP)
Quality Assurance (QA)
Quality Improvement (QI)
Quality Improvement Initiative (QII)
Quality Management (QM)
Quality Management Strategy (QMS)
Quality Management Unit (QMU)
Quality Strategy Committee (QMS)
Quality Strategy Workgroups (QSW)
Rural Health Centers (RHC)
Special Health Care Needs (SHCNs)
State Fiscal Year (SFY)
Surveillance and Utilization Review (SUR)