QUALITY IN MANAGED LONG-TERM SERVICES AND SUPPORTS PROGRAMS

November 2013

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

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LIST OF EXHIBITS

ACKNOWLEDGMENTS

ACRONYMS

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

AAAD	Area Agency on Aging and Disability
ACAP	Pennsylvania Adult Community Autism Program
ACL	Michigan Administration on Community Living
ADDS	Arizona Data Decision Support System
ADL	Activity of Daily Living
ADRC	Aging and Disability Resource Center
AHCCCS	Arizona Health Care Cost Containment System
AIT	Administrative Interview Tool
ALTCS	Arizona Long-Term Care System
ALTCS-EPD	ALTCS for the Elderly and Physically Disabled
AQR	Annual Quality Review
CAHPS	Consumer Assessment Health Care Providers and Systems
CC	Contract Coordinator
CDPS	Chronic Illness and Disability Payment System
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CI	Critical Incident
CMO	Chief Medical Officer
CMR	Care Management Review
CMS	HHS Centers for Medicare and Medicaid Services
CNA	Comprehensive Needs Assessment
COPD	Chronic Obstructed Pulmonary Disease
CRA	Contractor Risk Agreement
DD	Developmental Disability(ies) or Developmentally Disabled
DFPS	Texas Department of Family and Protective Services
DHHS	North Carolina Department of Health and Human Services
DM	Disease Management
DMA	North Carolina Division of Medical Assistance
DME	Durable Medical Equipment
DMH/DD/SAS	North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DTR	Denial, Termination, and Reduction
DWAC	Department Waiver Advisory Committee
EIM	Enterprise Incident Management
EQRO	External Quality Review Organization

ER	Emergency Room
EVV	Electronic Visit Verification
FEA	Fiscal Employer Agent
FFS	Fee-For-Service
FTE	Full-Time Equivalent
GAO	U.S. Government Accountability Office
GSA	Geographic Services Area
HCBS	Home and Community-Based Services
HEDIS	Health Effectiveness Data and Information Set
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HRQol	Health-Related Quality of Life
HSW	Habilitation Supports Waiver
I&R	Information and Referral
IADL	Instrumental Activity of Daily Living
IBNR	Incurred But Not Reported
ICF-ID	Intermediate Care Facility for Persons with Intellectual Disabilities
ICHP	Texas Institute for Child Health Policy
IDD	Intellectual and Developmental Disabilities
IDT	Interdisciplinary Team
IMT	Intra-departmental Monitoring Team
ISP	Individualized Service Plan
IT	Information Technology
LME	Local Management Entity
LOC	Level of Care
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MCP	Member-Centered Plan
MCQS	Member Care Quality Specialist
MDCH	Michigan Department of Community Health
MDHS	Michigan Department of Human Services
MDS	Minimum Data Set
MFP	Money-Follows-the-Person
MH	Mental Health
MHCP	Minnesota Health Care Programs
MHSIP	Mental Health Statistics Improvement Program
MI	Mentally Ill
MIS	Management Information System
MLTSS	Managed LTSS
MMIS	Medicaid Management Information System

MSC+	Minnesota Senior Care Plus
MSHO	Minnesota Senior Health Option
NCQA	National Committee on Quality Assurance
NF	Nursing Facility
OALS	Arizona Office of Administrative Legal Services
OBRA	Omnibus Budget Reconciliation Act
OCCP	Tennessee Office of Contract Compliance and Performance
OFR	Operational and Financial Reviews
OT	Occupational Therapy
P4P	Pay-For-Performance
PAE	Pre-Admission Evaluation
PCP	Primary Care Provider
PD	Physical Disability
PEONIES	Personal Experience Outcomes Integrated Interview and Evaluation System
PES	Participant Experience Survey
PIHP	Pre-paid Inpatient Health Plan
PIP	Performance Improvement Project
PMMIS	Pre-Paid Medical Management Information System
POC	Plan of Care
PPE	Potentially Preventable Event
PT	Physical Therapy
QA	Quality Assurance
QAPIP	Quality Assessment and Performance Improvement Plan
QCR	Quality Compliance Review
QI	Quality Improvement
QIC	Quality Improvement Council
QM	Quality Management
RAD	Resource Allocation Decision
RFP	Request for Proposal
RN	Registered Nurse
SA	Substance Abuse
SAS	Substance Abuse Services
SED	Serious Emotional Disturbance
SP	Service Plan
SSI	Supplemental Security Income
ST	Speech Therapy
SUD	Substance Use Disorder
TCA	Triennial Compliance Assessment

TCAD	Tennessee Commission on Aging and Disability
ThLC	Texas healthcare Learning Collaborative
UM	Utilization Management

EXECUTIVE SUMMARY

As of 2012, 16 states had managed long-term services and supports (MLTSS) programs for Medicaid beneficiaries. This is an exploratory study of how eight of these states implemented Medicaid MLTSS quality oversight in their programs. The eight state MLTSS systems studied are: Arizona Long-Term Care System (ALTCS); Michigan Managed Specialty Supports and Services; Minnesota Senior Care Plus and Minnesota Senior Health Options; North Carolina 1915(b)/(c) Medicaid Waiver for Mental Health/ Developmental Disabilities/Substance Abuse Services; Pennsylvania Adult Community Autism Program; Tennessee CHOICES in Long-Term Care; Texas STAR+PLUS Program; and Wisconsin's Family Care.

Under fee-for-service (FFS), the state's quality assurance focus is on monitoring long-term services and supports (LTSS) providers, including nursing facilities and intermediate care facilities for persons with intellectual disabilities as well as home care agencies and other home and community-based services (HCBS) providers, to ensure that the health and well-being of service recipients is safeguarded. When states contract with managed care organizations (MCOs) to assume responsibility for delivering all (or almost all) LTSS to MLTSS plan members, the state's quality assurance focus shifts to monitoring how well the MCOs meet their contractual obligations for meeting the needs of their enrolled members. Thus, in the MLTSS environment, states delegate the first line of quality oversight--the monitoring of service providers--to the MCOs.

The Centers for Medicare and Medicaid Services (CMS) has issued regulations requiring MLTSS MCOs to perform certain quality activities and through a combination of regulations and policy guidance, CMS has also specified what the federal Medicaid agency expects from states with respect to quality oversight of MCOs. However, states have considerable discretion as to how to meet these CMS requirements. This study describes similarities and differences in state approaches among eight states whose MLTSS programs had progressed beyond the initial start-up phase by the summer of 2013 when the case study research was conducted.

State Quality Assurance Oversight Infrastructure

The study found that Arizona (ALTCS) and Tennessee (TennCare) heavily leveraged the oversight infrastructure already in place to monitor medical services also provided by the participating MCOs. The other six states studied have established relatively free-look MLTSS oversight infrastructures. Four of the states (Minnesota, Tennessee, Texas, and Wisconsin) also delegate additional quality assurance and improvement activities to the external quality review organization (EQRO) beyond the EQRO activities that are federally-mandated.

States with free-standing MLTSS oversight infrastructures vary greatly in the magnitude of quality assurance staff employed relative to the number of Medicaid beneficiaries enrolled in MLTSS and relative to the number of participating MCOs that must be monitored. Wisconsin had the highest staffing ratios and North Carolina the lowest.

States also varied in their use of information technology to generate quality oversight reports electronically and provide automated tracking. The Texas and Tennessee MLTSS programs provided some examples of how information technology can enhance monitoring.

Monitoring and Improvement Activities

All MLTSS programs conduct routine audits; what varies greatly is their frequency and intensity of focus. Half the states conduct all audits annually. One state audits MCOs every other year and uses the off year to validate whether MCOs have implemented the corrective action plan based on the prior year's audits. Two states monitor MCOs on a three year cycle. One state conducts different types of audits with varying frequencies (annual, semi-annual, quarterly, and monthly).

There is considerable overlap in the performance measures states use. Many are the same as those developed for FFS 1915(c) waiver programs and include "process" as well as "outcome" measures. Typical process measures address: timeliness of screening, assessment, care planning and service delivery as well as critical incidence management and procedures for reporting and responding to grievances. Outcome measures specific to long-term care are few in number; health related outcome measures are more readily available and well defined. Where delivery of health and long-term care services is integrated, states are conceptually supportive of using health-related outcome measures to measure MCO performance. However, Medicaid officials also realize that if MCOs serve predominantly plan members who are dually Medicare/Medicaid eligible but the MCOs are not responsible for the Medicare-covered services, then the MCOs have little control over those providers and their accountability for health outcomes must be limited accordingly.

Six of the eight state MLTSS programs verify service receipt against what was authorized in the service plan; two states only verify service receipt against reimbursement. Only one state MLTSS program implements service verification on a real-time basis via an electronic visit verification (EVV) system that requires front-line home care workers to "clock-in." Failure to report in on schedule alerts provider agencies that they may need to deploy replacement workers. EVV also produces reports on missed and late visits by MCO, provider, and service type.

Seven states conduct mortality reviews on participants in HCBS waiver programs, but two only conduct such reviews on those considered especially vulnerable (e.g.,

services users with intellectual and developmental disabilities (IDD) or individuals with serious mental illness whose death was not anticipated).

All MLTSS programs require MCOs to obtain member feedback through the use of satisfaction or experience of care surveys. The survey instruments used and other means of obtaining member feedback vary greatly across the eight states. CMS expects states to involve MLTSS plan members in program evaluation and monitoring. However, only one state (Tennessee) requires each MCO to have advisory groups whose membership comprises at least 51% plan members.

All Medicaid managed care programs must have an ongoing series of performance improvement projects (PIPs) focused on clinical and non-clinical areas. The eight states varied greatly in the number of PIPs that MCOs are required to conduct related to LTSS (between one and three annually). In most states, MCOs individually develop and implement PIPs but in two states the MCOs work on PIPs collaboratively, which is especially helpful to providers that participate in more than one MCO's provider network.

The study identified multiple examples of states using monetary incentives, penalties, or withholds to support quality-related program expectations and goals.

Two states were in the process of developing MCO quality report cards.

Member Safeguards

Care coordination is the back-bone of MLTSS member safeguards. Some states mandate frequency of contact between care coordinators and members; others leave this to MCO discretion. Use of care coordination and requirements for frequency of use vary by LTSS populations (e.g., plan members with IDD receive care coordination routinely; whereas those with mental illness use it only sporadically because they rely more on mental health counselors and peers). Only four states specify care coordination ratios (i.e., numbers of care coordinators to plan members), which are recommended or developed collaboratively with the MCOs rather than mandated across the board. State approaches to monitoring MCO care coordination have evolved over time, in some cases becoming more prescriptive (e.g., requiring more frequent contacts with members, mandating the use of a statewide standardized assessment instrument).

CMS considers critical incident management highly important. At a minimum there must be provisions for mandatory reporting of abuse, neglect, or exploitation of LTSS service recipients. States typically delegate critical incident management to the MCOs but monitor their performance through audits and review of critical incident reports that MCOs must make to the states. States vary in their requirements for the frequency of critical incident reporting.

In most MLTSS programs studied, 24-hour back-up is a routine feature of the care delivery system through the use of MCO (or provider) round-the-clock hotlines or after-hours call-in systems to respond to members in need of assistance.

Balancing the Pros and Cons of Diversity and Flexibility Compared to Those of Standardization

Diversity is a traditional hallmark of the federal/state Medicaid program and flexibility--believed to encourage innovation--has been one of the core tenets of Medicaid MLTSS. Nevertheless, arguments can be made for more uniformity across states and MCOs in measuring the impact of MLTSS on beneficiaries' lives, particularly related to health outcomes and program participants' experience of quality of care and quality of life.

I. INTRODUCTION

A growing number of states have decided to expand their Medicaid managed care programs to encompass Long-Term Services and Supports (LTSS). From 2004 to 2012, the number of states with Medicaid managed LTSS (MLTSS) programs doubled from eight to 16, and ten more states are projected to implement MLTSS programs by 2014.[1] As states move their LTSS from a fee-for-service (FFS) environment to managed care, the nature of the state's quality oversight enterprise must ensure the compliance of the managed care organizations (MCOs) with whom they contract.

Under FFS, the state's quality focus is on monitoring providers (institutional providers, as well as those delivering home and community-based services (HCBS) and ensuring that the health and well-being of those served is safeguarded. The state's focus under managed care is monitoring the managed care entities to make certain that they meet contractual obligations for addressing the needs of their enrolled members. In the managed care environment, the first line of quality oversight is delegated to the MCO.

Among other obligations, the MCO must demonstrate to the state that:

- person-centered plans, based on comprehensive assessments, are developed with members;
- service plans meet members' needs and are responsive to their wishes for how services and supports will be delivered;
- services in the plan are actually delivered;
- services are coordinated (including health services);
- providers are responsive to members' changing needs and circumstances; and
- providers and the MCO address emerging member risk and critical events experienced by members.

In addition, Medicaid managed care regulations[2] require a further set of quality activities for the MCO not imposed in the FFS environment--Performance Improvement Projects (PIPs), an independent annual compliance review, as well as independent validation of the MCOs performance measures and PIP methodologies/results.

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

[2] Medicaid managed care regulations may be found in Code of Federal Regulations (CFR) 438: http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part438/content-detail.html. Accessed August 30, 2013.

Through a combination of the CFR 438 Medicaid managed care regulations and recent guidance on the essential elements of MLTSS programs,[3] the Centers for Medicare and Medicaid Services (CMS) provides states with expectations for quality oversight in MLTSS. CMS specifies what states must do. But, it is primarily at the states' discretion as to *how* they will implement CMS' requirements.

In this study, we explore how several states have designed their quality monitoring and improvement programs for MLTSS. We focus on the early adopters of MLTSS as well as those programs that are presently considered "established." As the findings of this report will demonstrate, states take somewhat different approaches to MCO oversight and we explore them in more detail below.

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[3] Centers for Medicare and Medicaid Services, Center for Medicaid & CHIP Services, 2013. *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs.* May 20, 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf. Accessed August 30, 2013.

II. STUDY APPROACH

The nature of our study is exploratory with the goal to understand how a handful of states have implemented Medicaid MLTSS quality oversight in their programs. This is not an evaluative study where we seek to assess or rank the states on the quality in their programs, or to assess their compliance with federal regulation or guidance. Rather, it is to learn how they have crafted their quality strategies, what constitutes its components, and how their approaches to quality may have changed over time and why. The most appropriate methodology for such a study is the case study approach.

During the spring and summer months of 2013, staff from Truven Health Analytics conducted site visits to MLTS programs in Michigan, Wisconsin and Texas. During the visits we carried out semi-structured in-depth interviews with state and MCO[4] Quality Assurance/Quality Improvement (QA/QI) staff. In two states (Texas, Wisconsin) we were also able to have discussions with the External Quality Review Organization (EQRO).

In addition, in the spring of 2012 prior to the initiation of this project, the Truven Health team had the opportunity to visit two other MLTSS programs in Arizona and Tennessee. We leveraged much of the information garnered in those visits for this study, augmented with follow-up phone interviews and e-mail exchanges during the course of the current project. Individuals on our team also had previous exposure to three other MLTSS programs in Minnesota, North Carolina and Pennsylvania which we have also drawn upon for this study; likewise, we conducted phone interviews with staff in these states to supplement existing information.

The MLTSS programs highlighted in this brief range from the earliest adopters in the late 1990s to programs initiated in 2009 and 2010. As shown in Exhibit 1, the populations served in these programs run the gamut from the aged and disabled to those with intellectual and developmental disabilities (IDD), autism and severe mental illness and substance use disorders (SUDs), with some programs integrating both health care and long-term care.

To guide the discussions with informants, Truven Health developed a discussion guide to elicit information on various quality topics covered by the study, including the state's infrastructure supporting quality activities, monitoring mechanisms, member safeguards, and changes in the state's quality management strategies over time. The discussion guide was used for the site visits, as well as for follow-up communications with MLTSS programs previously visited. It guided discussion as well with state staff

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[4] While we use the term "MCO" in this report to refer to entities who manage MLTSS services under contract to the state, technically the plans in Michigan, North Carolina and Pennsylvania are Pre-paid Inpatient Health Plans (PIHPs).

from whom we wanted to acquire additional detail on certain topics and/or to elicit information on recent changes in their quality systems.

EXHIBIT 1. Study States/Programs							
State	Program	Authority	Initiated	Populations	HCBS	Institutional	Health
AZ	Arizona Long-Term Care System (ALTCS)	1115	1988	Aged, Physically Disabled & IDD	X	X	X
MI	MI Medicaid Managed Specialty Support & Services Program	1915(b)/(c)	1998	IDD & MH	X	X	
MN	Minnesota Senior Care Plus (MSC+)	1915(b)/(c)	2005	Aged	X	X	X
	Minnesota Senior Health Options (MSHO)	1915(a)/(c) & Medicare	1997	Aged	X	X	X
NC	North Carolina 1915(b)/(c) Medicaid Waiver for MH/DD/SA Services	1915(b)/(c)	2005	IDD, MH & SA	X	X	
PA	Adult Community Autism Program (ACAP)	1915(a)	2009	Adults with Autism	X	X	X (OT, PT, ST & DME only)
TN	TennCare CHOICES in LTSS	1115	2010	Aged/Disabled	X	X	X
TX	Texas STAR+PLUS Program	1115	1998	Aged/Disabled	X	X	X
WI	Family Care	1915(b)/(c)	1999	IDD, Aged & Physically Disabled	X	X	X

We also relied on an environmental scan developed by Truven Health of the quality provisions found in MLTSS MCO contracts. This scan includes quality-related contract requirements for all eight MLTSS programs which we focus upon in this study.[5]

The body of this report attempts to summarize the multiple components of the quality management systems in the eight MLTSS programs. These components can be organized into three broad categories:

- State infrastructure for monitoring quality;
- Monitoring and improvement activities; and
- Member safeguards.

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[5] Rivard P., Jackson B., Rachel J., Seibert J., and Whitworth T. *Environmental Scan of MLTSS Quality Requirements in MCO Contracts*. Truven Health Analytics, Draft: August 31, 2013.

At the end of the report, some additional quality-related topics that we pursued with our informants are presented.

The Appendices at the end of the report provides individual detailed summaries of the various components of the quality strategies in each of the eight MLTSS programs. The information residing there was gathered from our interviews, documents provided by the state, MCO or EQRO, as well as documents publicly available on state websites. We provide these more in-depth summaries of each state so that the reader has access to the rich detail about the structure of their quality management programs.

III. STATE INFRASTRUCTURE FOR QUALITY MONITORING

CMS' recent guidance on the design of Medicaid MLTSS programs identifies the resources that a state must have for overseeing program quality. These include resources to:

- Conduct quality-focused audits;
- Evaluate MCO/provider quality reports;
- Trend data and identify areas for systems improvement;
- Validate corrective action plans;
- Develop and evaluate PIPs;
- Review/act on member feedback; and
- Ensure critical incidents/sentinel event are reported, investigated and addressed.

CMS's guidance also specifies that the resources that a state brings to bear (number and expertise of personnel, information technology assets) should be commensurate with the size and complexity of the program.

Among the study states we found that Arizona and Tennessee have heavily leveraged the oversight infrastructure used to monitor their managed health care plans--AHCCCS[6] and TennCare, longstanding Medicaid managed care programs on the medical side. The other study states have established relatively free-standing MLTSS oversight infrastructures. Some of the states (Minnesota, Tennessee, Texas, and Wisconsin) also delegate additional quality assurance and improvement activities to the EQRO (beyond those EQRO activities that are federally-mandated).

While we do not have sufficient information to offer direct comparisons among the states on resources they allocate to quality, Exhibit 2 provides a glimpse into the magnitude of staffing each state employs relative to the numbers of members in the program and number of MCOs it monitors. It is difficult to compare the staffing complement in Arizona and Tennessee with the other states due to their draw on resources from their overarching Medicaid managed care program. Excluding these two states as well as Pennsylvania (an outlier in terms of number of members enrolled--only 130), a cursory comparison shows a range of quality staffing ratios. They range from one state quality staff per 2,905 MCO members in Wisconsin to one per 21,215 MCO members in North Carolina. Since the primary focus of state quality monitoring is the MCO, perhaps a more meaningful comparison is the number of quality staff per MCO. Here too we see ranges, from approximately 0.36 state full-time equivalents (FTEs) per MCO in North Carolina to 1.75 state FTEs per MCO in Wisconsin. Our

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[6] AHCCCS--Arizona Health Care Cost Containment System.

comparisons in this instance are merely descriptive, but do raise questions for future inquiry about optimal staffing levels and whether there can be economies of scale with increased numbers of MCOs without sacrificing adequate monitoring.

EXHIBIT 2. State Staffing for Quality Management			
State	**LTSS Members**	**MCOs**	**Quality Staff**
AZ	52,521	4 (LTSS)	15
MI	172,500	18	19
MN	48,859	8	9
NC	84,861	11	4
PA	130	1	2
TN	31,890	4	2 Units in LTSS 1 Unit in TennCare (shared oversight)
TX	71,239	5	8
WI	33,000	9	1.5-3.0 FTE per oversight team (1 team per MCO)

The information technology capabilities of a state and how they support the quality enterprise are part of the infrastructure as well. A quality system is obviously much enhanced with the ability to generate reports electronically and provide automated tracking. Our case study programs provide some examples of how information technology enables enhanced monitoring. Texas's web-based portal allows the state, MCOs and the EQRO to view quality reports submitted by MCOs; they intend to offer access to providers in the future. Tennessee uses a customized off-the-shelf web-based tool to track receipt of all quality reports, corrective action plans and associated communications. All submissions from an MCO require action by a state employee to accept/reject the report/corrective action plan including the rationale for the disposition. This tool also documents all communications between the MCO and the state. In addition, Tennessee makes use of *GeoAccess* software to identify potential deficiencies in each MCO's provider network, including LTSS providers.

IV. MONITORING AND IMPROVEMENT ACTIVITIES

All of the programs we examined rely on a variety of mechanisms to assess quality of care and MCO compliance with contract requirements for delivering services and supports. In this section we focus on audits, MCO reporting, verification of service receipt, mortality reviews, member feedback, how members participate in quality oversight, the EQRO's contributions to monitoring and improvement activities, the role of PIPs, how states use monetary incentives and penalties to reinforce quality objectives, and the use of MLTSS report cards.

A. Audits

All the MLTSS programs conduct routine audits of MCOs. What varies among them is the frequency and intensity of focus. Half of the programs conduct annual audits in-house (Pennsylvania, North Carolina, Texas, and Wisconsin), and two delegate this responsibility to the EQRO (Texas, Wisconsin).

Currently, Michigan conducts audits every other year on each MCO; in the off year they focus on validating that the MCO has implemented its corrective action plan from the previous year. Both Arizona and Minnesota audit the MCOs on a three-year cycle. Tennessee conducts different types of audits with varying frequencies:

- Annual: Fiscal Employer Agent (FEA) Audit; Area Agencies on Aging and Disability[7] (AAAD) Audit; Money-Follows-the-Person[8] (MFP) Audit, Provider Qualifications Audit.

- Semi-annual: Care Coordination Audit; Critical Incident Audit.

- Quarterly: New Member Audit; Referral Audit.

- Monthly: Network Adequacy Audit.

Minnesota's audit process begins with annual audits conducted internally by each MCO; the MCOs submit the results of their audits to the state. Eighteen months following receipt of each MCOs audit report the state then conducts a "look-behind" audit focused on the MCOs implementation of remediation activities in response to any issues or deficiencies that the MCO had identified.

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[7] AAADs are responsible for information and referral activities and sit outside the MCOs.

[8] Money-Follows-the-Person Demonstration.

One of Tennessee's additional care coordination auditing activities that sits outside the semi-annual audit bears mentioning. "*Ride-alongs*" have been instituted where state staff accompany the MCO care coordinator on member visits and assess the care coordinator's ability to meet contractual care coordination requirements. These "*ride-alongs*" occur six times per quarter per MCO, with the state sitting down with MCO management staff to debrief afterwards.

B. Managed Care Organization Performance Reporting

Information on MCO performance is not always articulated as "performance measures" per say, but may be found in reports that states require the MCO to submit. Several of the MLTSS programs are "combo" waivers (i.e., programs combining the 1915(c) authority for Medicaid HCBS waivers with the managed care authority of the 1915(a) or 1915(b)). With combo waivers CMS requires that the state collect, use and report performance measures demonstrating the state's adherence to the 1915(c) assurances, most of which are quality-related. States typically require that the data for the assurance-based performance measures, or the measures themselves, be reported by the MCOs. In recent years the "Terms and Conditions" of 1115 demonstration waivers, another regulatory vehicle used for MLTSS, have required performance measures for some of the 1915(c) assurances as well.

It is not surprising that many of the performance measures in MLTSS programs are similar to those found in the FFS 1915(c) programs. Even if CMS did not mandate "c-like" measures, one would still expect similar measures given the commonality of populations and expectations for good practice in assessment, person-centered planning, and safeguards for member health and welfare. Many of the process measures that the case study states report are related to timeliness of screening, assessment, care planning and service delivery as well as the extent to which defined processes for addressing critical incidents and grievances are followed.

In both FFS and MLTSS there is keen interest in the development and use of outcome measures for Medicaid LTSS programs.[9,10,11,12,13,14] Consensus about what

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[9] National Committee for Quality Assurance. *Integrated Care for People with Medicare and Medicaid*. March 2013. http://www.ncqa.org/portals/0/public%20policy/NCQAWhitePaper-IntegratedCareforPeoplewithMedicareandMedicaid.pdf. Accessed September 26, 2013.

[10] Lind A, Gore S, Barnette L, and Sommers S. *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*. Center for Health Care Strategies. November 2010. http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf. Accessed September 26, 2013.

[11] Dembner A. *Putting Consumers First Promising Practices for Medicaid Managed Long-Term Services and Supports, Community Catalyst*. January 2013. http://www.communitycatalyst.org/doc_store/publications/putting_consumers_first_LTSSmanagedcare.pdf. Accessed September 26, 2013.

[12] Konetzka RT, Karon, SL, and Potter DEB. Users of Medicaid Home and Community-Based Services Are Especially Vulnerable to Costly Avoidable Hospital Admissions. *Health Affairs* 31, 2012. http://content.healthaffairs.org/content/31/6/1167.full.

constitutes "good" outcomes for individuals using LTSS is somewhat more elusive than in the health arena where treatment outcomes are more definitive. That said, the states in our study are collecting data on several outcome measures; some are population-specific and others are applied across populations.

EXHIBIT 3. Examples of Process Measures in Study States
• Timeliness of screening/assessment/reassessment (based on state standard)
• Timeliness of service plan development (based on state standard)
• Timeliness of service initiation (based on state standard)
• Timeliness from FEA referral to receipt of consumer-directed services (based on state standard)
• Timeliness of care coordinator face-to-face and telephonic contacts
• Care coordinator caseload & staffing ratio
• Percent of complaints received & resolved
• Late/missed visits by service type
• Percent of grievances received & resolved

Since there is considerable overlap in the measures used by the eight case study states, Exhibit 3 and Exhibit 4 present examples of some process and outcome measures, respectively, without identifying the states utilizing them. More details on performance measures employed by each state may be found in the Appendices at the end of this report.

EXHIBIT 4. Examples of Outcome Measures by Study States
• Number of episodes of law enforcement involvement
• Number of psychiatric inpatient & emergency room hospitalizations
• Number of mental health crisis interventions
• Percent in competitive employment
• Percent living in a private residence alone, with spouse or non-relative
• Number of substantiated recipient rights complaints per 100 beneficiaries served
• Increases in:
- Annual dental exams
- Diabetes management
- Annual gynecological exams
• Community tenure of persons transitioned from nursing homes
• Number of persons transitioned from nursing home to community
• Number of persons entering nursing home
• Potentially preventable readmissions
• Potentially preventable complications

The reader will notice that in Exhibit 4 some health-related outcomes are listed. Conceptually, states are supportive of including such measures, especially since one of

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[13] Galantowicz S. *Environmental Scan of Measures for Medicaid Title XIX Home and Community Based Services: Final Report*. AHRQ Publication No. 10-0042-EF. Agency for Healthcare Research and Quality, Rockville, MD. June 2010. http://www.ahrq.gov/research/ltc/hcbsreport. Accessed June 26, 2013.

[14] Maslow K, Ouslander J. *Measurement of Potentially Preventable Hospitalizations*. Long-Term Care Quality Alliance. January 2012. http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/PreventableHospitalizations_021512_2.pdf. Accessed September 26, 2013.

the hallmarks of MLTSS is coordination of LTSS and medical care, with the intended effect being the achievement of better health outcomes. However at this juncture Medicaid agencies are somewhat reluctant to include health outcomes as performance measures until their plans are fully integrated with Medicare. While the MCOs may be expected to coordinate with Medicare providers that their members use, ultimately they do not have control over those providers. The states argue that neither they nor their MCOs should be held accountable for outcomes over which they do not exert control. This argument should abate as states begin participating in the CMS Duals Demonstrations.

C. Verification of Service Receipt

Verifying the delivery of home and community-based LTSS services is a critical component of managed care oversight due to the vulnerability of populations served. Late or missed visits, especially those that provide assistance in essential every day activities, place the member at potential risk of untoward outcomes. Moreover, managed care entities are required by federal regulation to monitor delivery of services by providers as well as take corrective action if service delivery is late or missed.[15] In MLTSS, this requirement is closely connected to ensuring member safeguards, and important to allaying beneficiary and advocate fears that MCOs "skimp" on services in order to contain costs and maximize profit.

Five out of the eight programs verify service receipt against what was authorized in the service plan (Arizona, Michigan, Pennsylvania, Tennessee, Wisconsin); they compare whether members receive the services identified in their service plans. Two programs (Michigan, North Carolina) verify service receipt against reimbursement; the latter is a proxy approach because verification in this instance is not directly tied to the service plan. In seven out of the eight study states reviewed, states monitor service receipt retrospectively through reports submitted by the MCO.

Only in Tennessee is service verification done on a real-time basis. Tennessee utilizes an electronic visit verification (EVV) system where direct care providers clock-in and clock-out via phone from the member's home. The days and times that providers are expected to arrive are programmed into the system; if the worker does not clock-in within 15 minutes of the scheduled start time, an alert is sent to both the provider and the MCO. The MCO/provider is expected to deploy back-up workers and they, as well as the state, have the ability to track whether and when the replacement worker clocked in. The EVV system produces reports on missed and late visits by MCO, provider and service type.

The frequency of MCO reports on service verification varies from monthly in Arizona, and quarterly in Pennsylvania, to annually in North Carolina and Michigan.

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[15] Centers for Medicare and Medicaid Services, Code of Federal Regulations, 42 CFR 438.206.c.1.i-vi.

Although its approach is still retrospective in nature, Arizona has implemented a "gap report" strategy that the MCO must submit monthly. What distinguishes Arizona from the other retrospective approaches is that their reporting requirements go beyond counts of missed visits and includes the reason for the service gap as well as actions taken at the individual level to address the missed visit.

While the retrospective validation approach is the most common, unless the MCO has a systematic mechanism for being alerted in a timely fashion when service delivery is late or missed, deployment of needed back-up help cannot be assured. On the other hand, while the EVV system in Tennessee is considered by many as a promising practice, it does have potential cost implications associated with up-front installation, as well as costs associated with staffing resources to monitor the EVV system for no-shows. For this approach to be most effective, it needs to be monitored (by providers and the MCO) in real-time so that when an alert is sent indicating a worker no-show, either the provider or MCO proactively contacts the member to assess the immediate need, and then deploys a back-up worker as necessary. In addition, the EVVs approach may also pose some challenges for verifying self-directed services. One of the features of self-direction is that it allows members to have flexibility about the day and time of day a service is delivered. As currently configured, EVV is driven by the date/time the worker is supposed to arrive and if a member changes this without formally requesting a change, then a worker no-show alert will be triggered. Moving forward it will be instructive to follow how Tennessee addresses this seeming constraint in the EVV system.

D. Mortality Reviews

In 2008, the U.S. Government Accountability Office (GAO) recommended that CMS encourage states to conduct mortality reviews in 1915(c) HCBS waivers.[16] The mortality review process typically involves screening a death to ascertain whether it meets a pre-determined criteria for an in-depth review, investigation by a mortality review committee of circumstances that led to the death, a systems-level review to examine any commonalities across deaths to identify and recommend changes to reduce future risk of death.

The GAO was silent on the advisability of mortality reviews for 1915(c) waivers serving other populations and for MLTSS programs. However, good practice in community-based LTSS suggests that mortality reviews are an important oversight in LTSS program.[17] Among the programs reviewed, we found evidence that seven conduct mortality reviews. Six delegate this responsibility to the MCO. The Michigan program which enrolls members with severe mental illness and IDD requires investigation of unexpected deaths only. Arizona requires MCOs to conduct mortality

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[16] Government Accountability Office. *Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities*. GAO-08-529 May 23, 2008.

[17] National Home and Community-Based Quality Enterprise. *NQE Quality Brief: Mortality Investigation and Review in Medicaid Home and Community-Based Services Program*. April 27, 2012.

review for deaths among members with IDD only. The Tennessee Choices program, serving the Aged/Disabled population, does not require mortality reviews.

EXHIBIT 5. Member Feedback Surveys					
State	Entity Conducting Survey			Survey Type	Notes
	State	MCO	Contractor		
AZ	X	X		Satisfaction	
MI		X		MHSIP[1]	Mail survey to members with mental illness.
	X			Core Indicators	In-person survey with IDD members; 1 year grant from ACL[2] to cover costs of data collection; uncertain about sustainability due to cost.
MN	X			Satisfaction	Managed Care Public Programs Satisfaction Survey.
NC		X		Satisfaction	MCO must contract with external vendor; MCO surveys must be approved by the state.
			X	Core Indicators	In-person survey with IDD members.
PA		X			
TN			AAAD	Experience of Care	Based on items from the PES & MFP Quality of Life Survey items.
	X			HCBS Experience of Care	Participating in pilot study for CMS-funded HCBS Experience of Care Survey (external survey vendor).
			FEA	Satisfaction	Survey of consumer-directed members.
TX			EQRO	Experience of Care	LTSS-focused items added to CAHPS survey.
WI	X			Experience of Care	State-developed PEONIES.
		X		Satisfaction	Nature of survey at MCO discretion.
1. Mental Health Statistic Improvement Program Survey. 2. Administration on Community Living, Michigan Department of Health and Human Services.					

E. Member Feedback

CMS' recent MLTSS guidance calls for states and/or MCOs to measure members' experience of care and quality of life. All of the programs reviewed field either satisfaction or experience of care surveys, with most administering them on an annual basis. In some instances, the surveys are conducted by the state, whereas others are completed by the MCO. There are a few examples of these surveys being administered by a contractor (EQRO, AAAD,[18] FEA[19]). In a few cases, there is a dual-survey approach where both the state and either the MCO or another contractor conduct them. In Michigan, separate surveys are conducted with members having mental illness and

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[18] AAAD (Tennessee).

[19] FEA, for members directing their own services (Tennessee).

IDD. A few states use externally tested instruments (Mental Health Statistics Improvement Program [MHSIP], Core Indicators, Participant Experience Survey (PES), HCBS Experience of Care Survey) while others rely on state or MCO-developed instruments. In addition to surveying members, two of the programs conduct focus groups (Pennsylvania) or listening sessions (Wisconsin) with members.

F. Member Oversight

"Stakeholder engagement", inclusive of program oversight, is considered a key element in CMS' guidance document. Moving forward, CMS expects states to involve stakeholders, including members, in program evaluation and monitoring. CMS also expects states to require MCOs to convene member advisory committees to provide feedback on MCO MLTSS operations. We were therefore interested in learning how the established MLTSS programs engage members in monitoring and broader program oversight.

In Michigan, members sit on a quality committee and in North Carolina and Texas they have seats on advisory committees. Five programs require advisory committees or state staff to elicit input from members as part of an MCO's annual review or periodically through member focus groups. Three programs require MCOs to engage members either by having them serve on the MCOs' governing board (Wisconsin), or by having seats on the MCOs' Advisory and/or Quality Committees (Pennsylvania, Tennessee). Minnesota requires that each MCO have a Member Advisory Committee and that it meet regularly. Tennessee is unique in that it requires each MCO to have at least 51% of the seats on their Advisory Group be comprised of members or their authorized representatives.

G. External Quality Review Organization Responsibilities

Our interest in the EQRO pertains to activities they perform above and beyond those required under the Medicaid managed care regulations (compliance review, validation of encounter data, performance measures and PIPs). In particular, we were focused on additional quality management activities for which states employ EQROs in their MLTSS programs.

Four of the study states maintain a more traditional relationship with their EQRO (Arizona, Michigan, Minnesota, and Pennsylvania). But in Wisconsin, the EQRO takes on the added task of conducting the care management review in the MCOs. The EQRO assumes multiple additional tasks in Tennessee; rather than just validating PIPs they are involved in assisting the MCOs with PIP implementation, as well as responsibilities for training the MCOs and state staff on quality-related issues. The Tennessee EQRO also reviews all MCO corrective action plans from its annual compliance review and conducts a legislatively-mandated network adequacy review. The EQRO's scope of work in Texas includes focused studies, an annual satisfaction survey of members,

validating encounter data as well as developing data for the program's performance dashboard and planned MCO report cards.

H. Long-Term Services and Supports Performance Improvement Projects

All Medicaid managed care programs must have an ongoing series of PIPs focused on clinical and non-clinical areas.[20] In this inquiry, our interest was to discover the types of PIPs MLTSS programs conduct and if they have particular relevance to MLTSS services and/or populations--in essence whether the programs require their MCOs to engage in LTSS-specific PIPs.

PIPs often span more than one year as they require time for design and implementation, as well as time to review results and draw conclusions about the PIP's impact. Two of the study programs require the MCOs to conduct at least one LTSS PIP (Pennsylvania, Wisconsin); two states mandate two LTSS PIPs (Michigan, Tennessee); and two programs require three LTSS PIPs (North Carolina, Texas). In some states, some PIPs are dictated by the state, where in others they are at the discretion of the MCO. In some cases, the state may periodically mandate a specific PIP (e.g., in 2012 Tennessee required a PIP on rebalancing). In Texas, the EQRO establishes two of the three PIPs with the third at the MCO's discretion. Examples of LTSS PIPs in addition to Tennessee's rebalancing PIP include improvement initiatives on:

- Increased use of adult day care;
- Increased integration of behavior and physical health;
- Increases in depression screenings;
- Reduction in preventable hospitalizations;
- Increases in diabetic care; and
- Reduction in nursing facility rates.

Another approach that surfaced is an initiative in Texas and Minnesota where MCOs work together to develop collaborative PIPs. The advantages of this approach is that the MCOs are not working at odds with each other, and it is especially helpful for providers who may be involved in implementing PIPs who work for more than one MCO.

I. Quality-Related Financial Incentives, Penalties and Withholds

States have opportunity in designing their payment structures to reward MCOs for quality care/outcomes and to dis-incentivize them for performance below acceptable thresholds. In our interviews with states as well as in reviewing MCO contracts and other supporting information on state websites, we identified multiple examples of states

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[20] CFR 438.240.

using monetary incentives, penalties or withholds to support quality-related program expectations and goals.

Five programs offer quality-related incentives (Michigan, Minnesota, Tennessee, Texas, and Wisconsin), two issue monetary penalties (Minnesota, Tennessee) and four impose quality-related withholds (Minnesota, Pennsylvania, Tennessee, Texas). Monetary incentives are offered for:

- Transitioning members from institutional settings to community (Wisconsin, Tennessee).

- Increasing number of members with self-determination arrangements (Michigan).

- Improvement in number of consumers engaged in meaningful employment (Michigan).

- Improvement in number of consumers in private residence (Michigan).

- Improvement in number of consumers discharged from detoxification unit and seen for follow-up within seven days (Michigan).

- Superior clinical quality, service delivery, access to care and/or member satisfaction (Texas).

- Reductions in inpatient hospital costs (Texas).

- Optimal chronic disease care (limited to diabetes care, coronary/vascular disease care) (Minnesota).

In Michigan penalties can be levied for patterns of non-compliance, poor performance on a performance indicator standard, substantial inappropriate denial of services, and substantial or repeated health and safety violations. Tennessee is a strong advocate for assessing liquidated damages and its MCO contracts include detailed tables of amounts per infraction for "transgressions or omissions" ranging from threats to the smooth and efficient operation of the program to actions/inactions that result in threat to the member. Penalties can range from $100 per day to $10,000 per month depending on the breach.

Withholds of MCO payments are a tool used by Pennsylvania, Tennessee, and Texas to encourage delivery of good quality of care and services. Minnesota uses withholds for promoting MCO compliance with completing and submitting care plan audits and health risk screenings/assessments.

J. Report Cards

Two states were in the process of developing report cards at the time the study was being conducted. In Texas, the EQRO was assisting the state to finalize a legislatively-mandated MCO report card which will eventually be published on the state's website.

Tennessee was developing their report card from a combination of data from required MCO reports and audit results. At the time of the study, the report card was being used internally by state monitoring staff in MCO oversight. In the future the state expects to integrate the MCO performance data into the larger report card structure for the entire Medicaid managed care program (TennCare).

V. MEMBER SAFEGUARDS

Member safeguards are a critical component of the design of any MLTSS program, and serve to protect the health, safety and welfare of persons served, typically individuals with cognitive, emotional and/or physical vulnerabilities.

A. Care Coordination

Care coordination is the back-bone of member safeguards. Care coordinators are the system's eyes and ears for ensuring the well-being of members. They help the individual devise a service/support plan that is intended to meet their unmet needs, minimize risk, maintain health/function, and provide quality of life. Following the service initiation, it is then incumbent on the care coordinator to monitor the member's receipt of services as well as any circumstances that signal a need for a change in the plan (e.g., health change, mental health crises, change in the informal support system, increased risk taking, etc.) thereby minimizing the member's exposure to risk and consequent threats to health, functioning or quality of life. Assisting the person with coordination of acute care and behavioral health needs also falls to the care coordinator, as well as assistance with transitions related to hospitalizations and institutional care.

i. *Required Contacts with Members*

Given the importance of care coordinator contacts with members, we included this element in our case studies. Among the study states, contract frequency ranges from discretion of the MCO, to some combination of MCO discretion and required frequency of contracts, to prescribed frequency. A breakdown of these approaches is provided in Exhibit 6.

EXHIBIT 6. Frequency of MCO Care Coordinator Contacts	
State	**Frequency**
AZ	Semi-annually: members in nursing facilities Quarterly: community-based members
MI	Determined by need
MN	Annual
NC	No requirement
PA	Quarterly
TN	Annually: >21 in nursing homes Quarterly: <21 in nursing homes Monthly contacts, quarterly in-person: nursing home level of care living in the community Quarterly contacts, in-person annually: at risk of nursing home absent HCBS
TX	Semi-annual
WI	Quarterly contacts for the first 6 months After 6 months, MCO discretion

Both Michigan and North Carolina serve persons with mental illness and SUDs, as well as the IDD populations. North Carolina's newer program is modeled on Michigan's longstanding program and thus it is not surprising that their requirements are somewhat similar (no requirement and determined by need, respectively). In our interviews with state officials they noted that the care coordination needs for the mentally ill population is very different than for IDD members. The IDD population uses care coordination on a routine basis whereas members with mental illness use it only sporadically since their main support comes from mental health counselors and peers. When the mental illness population does utilize care coordination, it is typically for assistance with housing or other social services.

Wisconsin requires quarterly contacts for the first six months, and subsequently leaves it to the MCO to determine how frequently a given member needs to be contacted (but with a minimum of a yearly contact). By six months it is assumed that a relationship has been established between the member and the care coordinator and that the care coordinator can best determine how often contact is needed.

There is also variability around whether contacts must be conducted face-to-face, on the phone, or even by mail. For example, Texas allows any type of contact, whereas most of the other programs specify in-person. The exception is Tennessee which allows some contacts by phone as noted above.

ii.   *Care Coordination Ratios*

Four out of the eight study states do not specify any care coordination ratios. Only Arizona has absolute maximum ratios and uses a weighting scheme that accounts for the case-mix of the care coordinator's caseload (i.e., HCBS, nursing facility, assisted living).

The MCOs in Minnesota must submit their ratio policies to the state for review. If the MCOs ratios in Wisconsin vary from state norms, then the state may ask the MCO to justify its ratios. Tennessee recommends maximum ratios, but does not mandate them. However, if the MCO is found out-of-compliance with any care coordination contractual requirements and its ratios exceed that which the state has recommended, it is assessed liquidated damages.

iii.   *Evolution of Care Coordination*

It is always instructive to learn from states how their programs develop and change over time. Arizona told us that they discovered that when a member moved from one MCO to another, care plans and service authorizations often changed as a result of the MCOs using their own assessment instruments. For reasons of equity, the state decided to mandate a uniform assessment which has resulted in more consistency across the MCOs in service planning and authorizations. Arizona's move to a uniform assessment is consistent with emerging consensus that a uniform assessment

instrument is best practice and something CMS is now requiring for states participating in the Balancing Incentives Program.[21]

At the time of our interview, Texas was on the cusp of becoming more prescriptive in its requirements for care coordinator contacts with members due to a stakeholder feedback and a resulting legislative mandate. They were moving from two member contacts per year where it was the discretion of the MCO how to make the contact (in-person, phone, mail) to a system based on the member's acuity and risk levels with prescribed modes of contact for each level. For example, those at highest risk will receive two face-to-face visits per year by an *assigned* (consistent) care coordinator while those at lowest risk will receive two phone contacts per year by *any* care coordinator.

During interviews we also inquired about any instances of tension between care coordinators and MCO staff responsible for authorizing services. Both state and MCO staff in Michigan mentioned that care coordinators had been frustrated at an earlier point in time about service denials by the MCO's utilization management. Apparently the cause of many denials was inadequate documentation by care coordinators, which was subsequently addressed, and tension between the two had dissipated. In the discussion of this topic, both state officials and the MCO wanted it understood that in Michigan the MCOs (technically PIHPs), are non-profit entities (Community Mental Health Service Programs) and as such there was not profit motive or incentive to limit member utilization. Our discussions with North Carolina reported little tension between care coordinators and those authorizing services. The North Carolina program also serves members through non-profit MCOs, and they too mentioned that there was no financial motive for restricting services.

While Pennsylvania officials did not voice any current concern about care coordinator conflicts with the MCOs utilization management, they did mention that when the program was being developed that consumers and advocates were anxious that services would be reduced under managed care. The state tried to reframe the issue by focusing on the care coordinator's role to increase member independence with care coordinator support. Members' and advocates' initial concern have not resurfaced since program implementation.

B. Critical Incident Review and Investigation

In recent years, CMS has placed substantial emphasis on the importance of critical incident management processes in the 1915(c) HCBS waiver programs. With CMS' MLTSS guidance, this expectation now extends to MLTSS programs.

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[21] Mission Analytics Group. *The Balancing Incentive Program: Implementation Manual*. February 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/BIP-Manual-.pdf. Accessed September 26, 2013.

At a minimum, it is expected that there are provisions for the mandatory reporting of abuse, neglect or exploitation involving program participants. Robust critical incident management systems have structures and process in place for the receipt of reports and for their investigation, as well as protocols for urgent response when a member's health or safety is in immediate jeopardy.

The MLTSS study programs substantially delegate this responsibility to the MCOs. The states then monitor the MCO's management of critical incidents when they conduct audits and/or review MCO reports. Some states require the MCO to report certain events immediately or within 24 hours of their occurrence. For example, Wisconsin requires the MCO to report "egregious" incidents immediately. Michigan requires reporting certain deaths within 24 hours (i.e., those that occur as a result of suspected provider action/inaction and those that are the subject of a recipient's rights, licensing or police investigation). In Tennessee, any death or incident that could significantly impact the health or safety of a member must be reported to the state within 24 hours.

States vary in their approaches to overseeing the MCO's management of critical incidents. Several states require quarterly critical incident reports from the MCO (Tennessee, Texas, Wisconsin). Michigan requires reports to be submitted within 60 days following the end of the month when the incident occurred. In addition to requiring quarterly reports from MCOs, Tennessee also conducts semi-annual audits of the MCO's handling of critical incidents.

Only one program--Pennsylvania--has a centralized web-based system that serves as the repository for critical incident reports that must be submitted by the MCO within 24 hours. This system allows both the MCOs and the state to monitor how critical incidents are managed and resolved.

C. 24-Hour Back-up

Twenty-four hour back-up can refer to having an informal back-up plan in the event that a direct care worker does not show, as well as to the existence of a formal systems-level back-up when the informal back-up plan fails. This may include on-call care coordinators and/or providers.

Historically states resisted a formal 24-hour back-up provision in participant-directed services when it was first proposed for the Independence Plus designation for 1915(c) waiver programs (subsequently rescinded). And more recently, some states have been challenged to fully comply with the systems-level 24-hour back-up requirement in the MFP demonstrations. The argument against requiring 24-hour back-up in the FFS environment has been the cost associated with on-call personnel. Yet, in most MLTSS programs we investigated, 24-hour back-up is a routine feature of the care delivery system with MCO (or provider) round-the-clock hotlines or after-hours call-in systems in place to respond to members in need of assistance.

D. Ombudsman

Technically an ombudsman is a neutral party that can advocate for the member in disputes with the MCO or state regarding their services and supports. Three of the examined programs offered independent state ombudsman programs either devoted exclusively to the MLTSS program (Wisconsin) or to Medicaid managed care more generally (Texas, Minnesota).

Four programs (Michigan, Tennessee, Texas, and Wisconsin) also require that the MCO offer ombudsman-like services to their members, but these services are clearly not independent as these services are provided by MCO staff. The MCOs refer to these positions as variably as "member advocates", "member rights specialists" or "customer services".

In addition to advocacy, responsibilities for both the independent ombudsmen and those fulfilling ombudsman-like roles in the MCOs assume similar additional functions. These additional tasks include member/family education about the availability of services and how to access services and the complaints/appeals process. Both may also have duties related to tracking grievances and making recommendations for improvement to the provision of care. Exhibit 7 summarizes the ombudsman functions assumed by the state and MCOs in each program.

EXHIBIT 7. MCO Ombudsman Function and State Ombudsman Programs								
	AZ	MI	MN	NC	PA	TN	TX	WI
MLTSS/Medicaid State Ombudsman Program								
Education			X				X	X
Advocacy/Assistance			X				X	X
Tracking/Quality Improvement			X				X	X
MCO Ombudsman Functions								
Education		X				X	X	X
Advocacy/Assistance		X		X[1]		X	X	X
Tracking/Quality Improvement		X				X	X	
1. Through the North Carolina Division of Mental Health.								

VI. OTHER QUALITY CONSIDRATIONS

As we talked with states a few other issues pertinent to quality in MLTSS emerged. The first of these was how aspects of their quality management system had developed since program inception. Several states' comments revolved around the evolution of performance measures. Michigan had decreased the number of measures dramatically over time, from approximately 50 to fewer than 20. They were motivated to scale back due the expense associated with the EQRO having to validate the larger number of measures.

Wisconsin told us that they had moved from relying exclusively on process measures to more of a balance between process and member outcome measures. Comments by two other states were more of an aspirational nature regarding future developments in measurement--one wishing to incorporate more outcome measures (Texas) and another hoping to use HCBS Experience of Care measures under development by CMS (Tennessee).[22] Related to the discussions surrounding outcome measures was one state's observation that they had evolved their PIPs from an administrative focus to ones concentrating on quality of care improvements and health outcomes (Texas).

Other changes noted were increased standardization of MCO processes allowing for more effective state oversight (Wisconsin), expanding the EQRO's role (Texas), increasing the number and expertise of state monitoring staff (North Carolina), and developing an individually-based critical incident monitoring system (Michigan).

In addition, a couple of states (Tennessee, Texas) noted that MLTSS quality monitoring is much more data-driven and that they were using more sophisticated data systems for evaluating the provision of care than they had under the 1915(c) waiver programs. Tennessee in particular pointed to the EVV system (described earlier in this report) that it implemented at the outset of its MLTSS program. While not making any comparison to service receipt performance under the predecessor 1915(c) waiver, they cited recent performance of greater than 96% of scheduled in-home visits delivered, and 99.7% delivered on time. They attribute this achievement to the EVV system with the ability to resolve missed/late visits in real-time. More related to member health outcomes, Texas has empirical evidence of improved treatment of Chronic Obstructed Pulmonary Disease under its MLTSS program, and Pennsylvania cited an increase in competitive employment as a positive program impact.

Another topic we explored was states' experience with the flexibility afforded in the Medicaid managed care regulations for quality management as compared to the more

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[22] Centers for Medicare and Medicaid Services. *Planning and Demonstration Grant for Testing Experience and Function Tools in Community-Based Long Term Services and Supports (TEFT) (CMS-1H1-13-001).* June 27, 2013. http://www.grants.gov/web/grants/view-opportunity.html?oppId=195253. Accessed September 26, 2013.

prescriptive requirements associated with the 1915(c) HCBS waiver requirements. Tennessee acknowledged that the 1915(c) requirements influenced the design of their quality strategy but that they appreciated the ability to customize the quality management approach in their MLTSS program. North Carolina mentioned that the 1915(b) authority allows them to contract with select providers who offer higher quality care, whereas otherwise they would have to adhere to the "any qualified provider" stipulation under Medicaid FFS. And, at the time of our interview, Michigan was in discussions with CMS to substitute MCO accreditation for state audits, augmented by EQRO record reviews; that flexibility is not a current option under the 1915(c) waiver authority.

VII. DISCUSSION

Diversity is a hallmark of the state-federal Medicaid program. The saying goes: "If you've seen one Medicaid program, you've seen one Medicaid program." In terms of MLTSS quality, the same holds true to a large extent. CMS has always accorded states discretion in the design and operation of their Medicaid programs, including quality monitoring, as long as they adhere to Medicaid regulations. States' responsibility to exercise administrative authority over their Medicaid programs is one of those expectations. Administrative authority requires that the Medicaid agency assume ultimate responsibility for oversight of any program functions it contracts out or delegates to other entities. But even administrative authority can be implemented in a manner as seen fit by a particular state, as long as approved by CMS.

Flexibility is also an underlying tenet of Medicaid MLTSS--affording MCOs opportunity to coordinate and deliver care in innovative ways suitable to the needs and desires of beneficiaries with long-term disability. Flexibility encourages innovation and allows the states and MCOs to be responsive to local conditions, cultures and the diversity of the MLTSS population. CMS acknowledges that states have options for how they address the essential elements of a MLTSS program outlined in its recent guidance document. Not surprising, across the programs studied we found a fair amount of variability in how states structure quality oversight in their MLTSS programs. By and large, however, all have integrated into their quality strategies the quality-related structures and processes delineated by CMS' guidance on the essential elements in MLTSS programs--but differently.[23]

While it would be imprudent to stifle diversity in how states design their quality infrastructures, processes and procedures, an argument can be made for more uniformity in measuring the impact of MLTSS on beneficiaries' lives, particularly outcomes related to health, experience of care and quality of life. In the commercial health marketplace as well as in Medicaid and Medicare, there has been a convergence toward adoption of rigorously tested health effectiveness and experience of care metrics as exemplified by Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment Health Care Providers and System (CAHPS),[24] respectively. Measures as these allow for "apple-to-apple comparisons" across providers, plans and states and are widely used by commercial plans, hospitals, providers and federally-

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[23] In those instances where a state appears not to have implemented all the essential quality elements delineated in CMS' guidance document, we remind the reader that our data collection occurred prior to, and approximately contiguous with, the release of CMS' directive in May 2013. As such, this study's description of state practices (or their absence) to assess compliance with federal expectations should be avoided.

[24] CAHPS is actually a family of measure sets, focusing on consumers' experience with different aspects of the health care delivery. Separate CAHPS instruments have been developed and tested for assessing consumer experience of health plans, hospitals, dental services, Medicaid, home health, nursing home, prescription drug plan, clinician and group, behavioral health, patient-centered medical home, and Medicare Advantage plans.

funded programs across the nation.[25] Another initiative along these lines is CMS' recent specification of a core set of health care quality measures for Medicaid-eligible adults as required by Section 2701 of the Affordable Care Act.[26] Items in this set are based largely on previously tested items and draw upon both HEDIS and CAHPS. However, the focus of these measures is on health care, not on LTSS. To fill this gap, CMS has invested in the development and testing of an HCBS Experience of Care survey for Medicaid programs for which CAHPS certification will be sought. This initiative will result in a cross-population survey so that "apples-to-apples" comparisons can be made across programs that serve the frail elderly, adults with disability, and persons with IDD. The instrument will be appropriate for use in both the FFS and MLTSS settings and thus will afford comparison between consumer-experienced care in those environments as well. At least one of the MLTSS programs in our study was intending to participate in the testing of this new survey.

In closing, we reiterate that the quality enterprise in MLTSS--for states, MCOs, providers and EQROs--is one with multiple and simultaneously moving parts. It requires sufficient investments in personnel and information technology resources as well as leadership's commitment to keep all engaged and aligned. As this report demonstrates, there are several tacks that states can take for assessing MCO and provider performance and for monitoring member well-being. We hope that the information on the myriad of ways states structure MLTSS quality management will be helpful to states embarking upon new programs as well as to those established programs that may be taking a second look at different options for quality.

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[25] Thurston Toppe, K. NCQA Medicaid Managed Care Toolkit. National Committee for Quality Assurance. March 2012. http://www.ncqa.org/Portals/0/Public%20Policy/2012_NCQA_Medicaid_Managed_Care_Toolkit_Summary_-_March_2012_Final.pdf. Accessed September 26, 2013.

[26] Centers for Medicare and Medicaid Services. *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set)*. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf. Accessed September 26, 2013.

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This report summarizes AHCCCS (the single State Medicaid Agency) quality improvement strategy, including history of the program, the process for overall quality strategy development, the objectives of the strategy, how quality and appropriateness of care are assessed, improvement interventions undertaken, and the strategy's effectiveness.

Center for Health Systems Research and Analysis, University of Wisconsin-Madison. (2012). *PEONIES Member Interviews: Final Report.* http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf. Accessed June 21, 2013.

This report summarizes the purpose, methodology, and findings of the PEONIES survey developed by the Wisconsin's Department of Health Services.

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

This document provides states with guidance on the elements CMS considers essential for any Medicaid MLTSS programs, both those that currently exist as well as those under development.

Centers for Medicare and Medicaid Services. *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid* (Medicaid Adult Core Set). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf. Accessed September 26, 2013.

The report presents a core set of health care quality measures for use by states to assess health care quality delivered to the adult Medicaid population.

Centers for Medicare and Medicaid Services. (June 27, 2013). *Planning and Demonstration Grant for Testing Experience and Function Tools in Community-Based Long Term Services and Supports (TEFT)*. Publication No. CMS-1H1-13-001. http://www.grants.gov/web/grants/view-opportunity.html?oppId=195253. Accessed September 26, 2013.

> This RFP is a call for states to apply for TEFT grants to support state use of a cross-disability experience of care survey and a setting/population-agnostic assessment tool for use in Medicaid HCBS programs. It also supports states in the development and use of e-LTSS records and HCBS Personal Health Records.

Dembner, A. (November 2012). *Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports*. Community Catalyst, Inc. http://www.communitycatalyst.org/doc_store/publications/putting_consumers_first_LTSSmanagedcare.pdf. Accessed May 13, 2013.

> This paper discusses the benefits and risks of Medicaid MLTSS for the consumer. It addresses strategies for minimizing risks and maximizing consumer benefits, from program development through operation and monitoring phases.

Family Care. *An Overview of Wisconsin's Family Care Program*. http://www.dhs.wisconsin.gov/ltcare/pdf/FCoverview.pdf. Accessed June 21, 2013.

> This paper is an overview of Wisconsin's Family Care Program, including program history and operation.

Galantowicz, S. (June 2010). *Environmental Scan of Measures for Medicaid Title XIX Home and Community Based Services: Final Report*. Agency for Healthcare Research and Quality, AHRQ Publication No. 10-0042-EF. http://www.ahrq.gov/research/ltc/hcbsreport. Accessed 6-26-2013.

> This paper is an environmental scan of measures used in Medicaid HCBS programs and includes measures that address functioning, satisfaction, and program performance.

General Accountability Office. (May 23, 2008). *Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities*. Publication No. GAO-08-529.

> This GAO report examined 14 states' approach to mortality review for Medicaid HCBS waiver programs serving people with developmental disabilities. The report includes the key components of what should constitute a mortality review process. The GAO recommended that CMS encourage states to conduct mortality reviews in HCBS programs.

Jones, J., Coberly, S., Martineau, M. (May 11, 2012). *Medicaid Managed Long-Term Services and Supports (MMLTSS): Increasing State Interest and Implications for Consumers, Quality of Care, and Providers and Costs*. National Health Policy Forum. http://www.nhpf.org/library/details.cfm/2894. Accessed May 13, 2013.

> This report recapped lessons learned from Medicaid MLTSS programs, identified the cost-savings and quality outcomes of these programs, and reviewed the actions taken by CMS in trying to help states move to MLTSS models. It also addresses consumer concerns and protections to be considered when implementing the MLTSS programs.

Kaiser Commission on Medicaid and the Uninsured. (2011). *Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider*. The Henry J. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/examining-medicaid-managed-long-term-service-and/. Accessed May 13, 2013.

> This paper examines issues states may face when considering moving LTSS populations and benefits from FFS to managed care. The authors encourage states to appreciate amount of time, expertise, and financial resources needed to make MLTSS programs successful.

Konetzka R.T., Karon S.L., and Potter, D.E.B. (2012). *Users of Medicaid Home and Community-Based Services Are Especially Vulnerable to Costly Avoidable Hospital Admissions*. Health Affairs, (31). http://content.healthaffairs.org/content/31/6/1167.full.

> This article reports on an analysis of Medicare and Medicaid data to identify the prevalence of potentially avoidable hospital admissions among users of Medicaid HCBS. The researchers found that users of Medicaid HCBS were particularly vulnerable to avoidable hospital admissions, compared to the full Medicaid and United States populations, and that these hospitalizations occur at substantial cost to the public payers.

Lind, A., Gore, S., Barnette, L., Somers, S. (November 2010). *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*. Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf. Accessed May 13, 2013.

> This paper offers a roadmap, culled from state best practices, and highlights key elements for MLTSS that result in high-quality, consumer-focused, and cost-effective care.

Lipson, D., Libersky, J., Machta, R., Flowers, L., Fox-Grage, W. (July 2012). *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports.* AARP Public Policy Institute. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf. Accessed May 13, 2013.

This report addresses capacities that state Medicaid agencies need to monitor the performance of MLTSS programs and identifies promising practices in state oversight, as well as the monitoring capacities that should be in place when states begin to implement new or expanded MLTSS programs.

Lipson, D., Stone-Valenzano, C. (February 2013). *The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program*. Mathematica Policy Research, Inc. http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt11.pdf. Accessed May 13, 2013.

The report reviewed best practices and lessons learned from multiple states that have implemented both MFP programs and MLTSS. The key findings leading to increased synergy between MFP and MLTSS include identifying overlapping target groups, defining roles and responsibilities, harmonizing monitoring and reporting requirements, and creating other partnerships between MFP and MLTSS programs.

Maslow, K., Ouslander, J. (January 2012). *Measurement of Potentially Preventable Hospitalizations. Long-Term Care Quality Alliance*. http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/PreventableHospitalizations_021512_2.pdf. Accessed September 26, 2103.

This white paper describes and analyzes quality measures that have been developed to identify potentially preventable hospitalizations. It was developed to provide information and recommendations to the Long-Term Care Quality Alliance to select quality measures and prioritize next steps to improve identification of potentially preventable hospitalizations for frail and chronically ill adults and older people.

METASTAR, Inc. *External Quality Review Report: Wisconsin Medicaid Managed Long-Term Care- Family Care, Family Care Partnership and Program of All-Inclusive Care for the Elderly: State Fiscal Year 2011-2012*. http://www.dhs.wisconsin.gov/ltcare/statefedreqs/eqro11-12.pdf. Accessed June 21, 2013.

External Quality Review report for Wisconsin's Medicaid MLTSS programs, July 2011-June 2012.

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(MHCP) Managed Care, as Compared to Fee-for-Service*.
https://mplus.mnpals.net/vufind/Record/007672698. Accessed September 16, 2013.

This paper a preliminary report on the value of Medicaid managed care in
Minnesota, relative to FFS. In addition to some initial findings it lays out the criteria
the final report will use for evaluating the value of managed care.

**Minnesota Department of Human Services, Performance Measurement and
Quality Improvement Division**. (October 2011). *Managed Care Public Programs
2012 Quality Strategy*. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4538-ENG.
Accessed August 20, 2013.

This report describes the Minnesota Department of Human Services' strategy for
assessing and improving the quality of health care services offered by managed
care plans for people enrolled in Medical Assistance and MinnesotaCare.

Mission Analytics Group. (February 2013). *The Balancing Incentive Program:
Implementation Manual*. http://www.medicaid.gov/Medicaid-CHIP-Program-
Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/BIP-
Manual.pdf. Accessed September 26, 2013.

This manual provides guidance to states in implementing the three structural
changes in their systems of community-based LTSS: a No Wrong Door/Single Entry
Point (NWD/SEP) eligibility determination and enrollment system; Core
Standardized Assessment Instruments; and Conflict-Free Case Management..

National Committee for Quality Assurance. (March 2013). *Integrated Care for People
with Medicare and Medicaid*.
http://www.ncqa.org/portals/0/public%20policy/NCQAWhitePaper-
IntegratedCareforPeoplewithMedicareandMedicaid.pdf. Accessed September 26, 2013.

This paper reviews strategies for measuring and evaluating quality and person-
centeredness in integrated care systems.

National Home and Community-Based Quality Enterprise. (April 27, 2012). *NQE
Quality Brief: Mortality Investigation and Review in Medicaid Home and Community-
Based Services Program*.

This brief outlines issues states should consider when developing mortality
investigation and review policies and procedures for Medicaid HCBS participant
deaths.

Rivard, P., Jackson, B., Rachel, J., Seibert, J., Whitworth, T. (September 2013). *Environmental Scan of MLTSS Quality Requirements in MCO Contracts*. Truven Health Analytics.

> This report summarizes the quality requirements that states include in their contracts with MCOs for their Medicaid MLTSS programs.

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

> This paper reports the findings of a national environmental scan of all Medicaid MLTSS programs implemented as of June 2012 and a projection of future programs through January 2014.

Synovate. (April 10, 2009). *Arizona Long Term Care System (ALTCS) Satisfaction Survey 2008: Report of Findings*. http://www.azahcccs.gov/shared/Downloads/surveys/ALTCS_Satisfaction_Survey_2008-FullReport.pdf. Accessed August 22, 2013.

> This report highlights the findings from a survey on satisfaction with care and services provided by the ALTCS for the Elderly and Physically Disabled (ALTCS-EPD) program and represent input from members across all eight ALTCS-EPD program contractors in all three of the care settings in which members reside (nursing facility, assisted living, and home).

Texas Medicaid Managed Care STAR+PLUS Behavioral Health Survey Report Fiscal Year 2011. http://www.hhsc.state.tx.us/reports/2013/EQRO-Behavioral-Health-FY2011.pdf. Accessed July 17, 2013.

> This report, prepared by the Texas' EQRO, provides results from the state fiscal year 2011 STAR+PLUS Behavioral Health Survey which documents customer satisfaction and experience of behavioral health services.

Texas Medicaid Managed Care STAR+PLUS Home- and Community-Based Services Waiver Study Report Contract Year 2012.
http://www.hhsc.state.tx.us/reports/2013/EQRO-STAR-PLUS-Waiver.pdf. Accessed July 17, 2013.

The purpose of this study was to: (1) describe and categorize the types of HCBS provided to Texas STAR+PLUS members; (2) examine perceptions STAR+PLUS members and service coordinators about the process of developing an ISP; (3) assess the involvement of members and their families in decisions regarding their care; and (4) assess members' experiences and satisfaction with the HCBS they receive.

Texas STAR+PLUS Program Adult Member Survey Report, Fiscal Year 2011.
http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pdf. Accessed July 17, 2013.

This report provides results from the fiscal year 2011 STAR+PLUS Adult Member Survey and offers information on health status as well as member experiences and general satisfaction with the care they receive through the Texas STAR+PLUS program.

Truven Health Analytics (as The MEDSTAT Group, Inc.). *Participant Experience Survey (PES) Tools.* For the Centers for Medicare and Medicaid Services.
http://nasuad.org/hcbs/article/participant-experience-survey-pes-tools. Accessed March 5, 2014.

These interview tools capture feedback directly from waiver participants about the supports and services they receive through home and community-based services waivers. States can use the data gathered through the surveys to calculate performance indicators to monitor quality within waivers. There is one PES geared for frail elderly and adults with physical disabilities and one for adults with intellectual and/or developmental disabilities.

Under Development by the National Association of State Units on Aging and Disability-- NCI-AD--Expanding the National Core Indicators for Aging and Disability Services.
Presented at the 2013 NASUAD HCBS Conference.
http://www.nasuad.org/documentation/HCBS_2013/Presentations. Accessed October 11, 2013.

This presentation addressed expanding the National Core Indicators for the aged and disabled populations.

Wisconsin Department of Health Services, Family Care. *2010 Family Care Member Satisfaction Survey Results*. http://www.dhs.wisconsin.gov/LTCare/Reports/PDF/satisfactionrpt2010.pdf. Accessed June 10, 2013.

This report discusses the program findings and methodology of the satisfaction survey conducted by the State of Wisconsin on its Family Care MLTSS program.

Wisconsin Department of Health Services. *Family Care Contract between Department of Health Services Division of Long Term Care and <<Name of MCO>>*. http://www.dhs.wisconsin.gov/ltcare/statefedreqs/cy2012mcocontract.pdf. Accessed June 21, 2013.

This document is the Family Care Contract between the Wisconsin Department of Health Services and MCOs. It includes contract requirements for MCO governance, consumer and member involvement, eligibility, enrollment and disenrollment, among others.

Wisconsin Department of Health Services, Division of Long-Term Care. *Long-Term Care In Motion: Wisconsin's Long Term Care Programs*. http://www.dhs.wisconsin.gov/publications/P0/p00318_2011.pdf. Accessed June 21, 2013.

2011 report on Wisconsin's IRIS and Family Care Programs.

Zubritsky, C., Abbott, K., Hirschman K., Bowles K., Foust, J., Naylor, M. (2012). *Health-Related Quality of Life: Expanding a Conceptual Framework to Include Older Adults Who Receive Long-Term Services and Supports*. The Gerontologist, 53(2): 205-210. http://gerontologist.oxfordjournals.org/content/53/2/205.full.pdf+html. Accessed May 13, 2013.

Journal article exploring multi-dimensional health-related quality of life models and concepts.

APPENDICES

State MLTSS Quality Management Summaries

APPENDIX A. Arizona Long-Term Care System

APPENDIX B. Michigan's Managed Specialty Supports and Services

APPENDIX C. Minnesota Senior Care Plus and Minnesota Senior Health Options

APPENDIX D. North Carolina's 1915(b)/(c) Medicaid Waiver for Mental Health/
Developmental Disabilities/Substance Abuse Services

APPENDIX E. Pennsylvania's Adult Community Autism Program

APPENDIX F. Tennessee's CHOICES in Long-Term Care

APPENDIX G. Texas's STAR+PLUS Program

APPENDIX H. Wisconsin's Family Care

APPENDIX A. ARIZONA LONG-TERM CARE SYSTEM

Element	Description
MLTSS Program	Arizona Long-Term Care System (ALTCS)
Lead Agency	Arizona Health Care Cost Containment System (AHCCCS)
Medicaid Authority	1115 Research and Demonstration Waiver
Inception	1988-1989
Year LTSS Added	At inception
Groups Enrolled	Elderly, physically disabled, and DD
# Enrolled	52,251 (May 2012)
1. State Quality Oversight Infrastructure	Infrastructure for oversight of the ALTCS program is integrated into its quality infrastructure for the larger AHCCCS Medicaid Managed Care system. The state employs nearly 75 staff to monitor MCOs and oversee their contracts and service provision. The following entities within AHCCCS are engaged in monitoring ALTCS: • Acute Care Operations; • ALTCS Operations; • Reinsurance; • Data Analysis and Research; • Medical Management; • Clinical QM; • OALS.
2. State IT Infrastructure for Supporting Quality Oversight	**PMMIS**--The state uses an integrated information infrastructure known as the PMMIS to satisfy the processing and reporting needs of the MCOs. It is composed of 11 core subsystems, 5 reporting and quality oversight subsystems, and a security subsystem to provide extensive information, retrieval, and reporting capabilities to satisfy the data needs of the state, CMS, other state and federal agencies, counties, providers and members. The system processes MCO encounters for all members and supports the monitoring of service utilization, quality of care, and program expenditures. The state noted that the PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the MLTSS program. **ADDS**--Generates reports on performance measures, utilization data), recipient enrollment and demographic information, as well as specialized queries. There are more than 100 separate measures in ADDS that can be selected to monitor and improve quality.

3.	MCO Quality Oversight Responsibilities	The MCO is required to have several key staff position for quality oversight/reporting including: • Medical Director/CMO, who is a state licensed physician, who is involved in all major clinical and QM components of the MCO; oversees the QM/PI program monitoring, and evaluation activities; and, serves as chair to quality oversight committees. • QM Coordinator whose primary functions include ensuring individual and systemic quality of care; integrating quality throughout the organization; implementing process improvement; resolving, tracking and trending quality of care grievances; and, ensuring a credentialed provider network. • Performance/QI Coordinator whose responsibility is to focus organizational efforts on improving clinical quality performance measures; develop and implement PIPs; utilize data to develop intervention strategies to improve outcomes; and, report QI/performance outcome. The MCO must ensure that the QM/QI Unit within the organizational structure is separate and distinct from any other units or departments (e.g., Medical Management or Case Management units).
4.	State Audits of MLTSS Program	The state conducts administrative OFR of each MCO to meet the federal requirements, as well as to determine the extent to which each MCO meets the state's contract requirements, policies, and additional federal and state regulations. The OFR includes the following areas that are reviewed at least every 3 years (although some areas are reviewed more frequently due to new requirements, compliance concerns and/or specific areas of interest): • Behavioral Health; • Case Management; • Claims System; • Corporate Compliance; • Cultural Competency; • Delegated Agreements; • Delivery System; • General Administration; • Grievance System; • Maternal and Child Health; • Medical Management; • QM; • QI; • Reinsurance; • Third Party Liability. The state also uses the OFR to increase its knowledge of each MCO's operational and financial procedures; provide technical assistance where needed; identify areas for improvement; and, areas of noteworthy performance and accomplishment.

		The state provides oversight of MCO case management through the following reports and processes:
		• Annual OFR;
		• Audit of case management administrative functions;
		• Audit of member case files/charts;
		• Member satisfaction surveys;
		• Interviews with case managers;
		• Standardized reports on programmatic requirements (e.g., timely case manager visits, CES averages);
		• Annual Case Management Plan;
		• Service Gap Reporting/Non-Provision of Services--Monthly and semi-annual reporting, documenting when services are not provided as authorized.
5.	Performance Measures and Quality-Related Reports	The state requires Performance Measures for all member populations. In addition, the state may also analyze and report results by line of business/program, GSA or county, and/or applicable demographic factors to identify opportunities for improvement. The following is a list of MCO-required performance measures:
• Access to Behavioral Health Provider (encounter for a visit) within 7 days of being designated as "active care" for an initial visit.
• Access to Behavioral Health Provider (encounter for a visit) within 23 days of being designated as "active care" for an initial visit.
• ADL Maintenance/Improvement (functional status assessment): DELAYED IMPLEMENTATION, Tabled for CYE 2014.
• Screening for Clinical Depression and Follow-Up Plan: DELAYED IMPLEMENTATION, Tabled for CYE 2014.
• Advance Directives.
• Use of High Risk Medications in the Elderly: DELAYED IMPLEMENTATION, Tabled for CYE 2014.
• HCBS Member Satisfaction Survey--This survey is currently being developed. Results will not be reported out as performance measures; rather, the state will meet with contractors following receipt of survey results to discuss and plan future interventions, which may include opportunities to sustain positive feedback or Corrective Action Plans in areas of lower satisfaction.
• Use of High Risk Medications in the Elderly: DELAYED IMPLEMENTATION, Tabled for CYE 2014.
• Medication Reconciliation Post Discharge: DELAYED IMPLEMENTATION, Tabled for CYE 2014.
• CAHPS Health Plan Survey v 4.0--Adult Questionnaire with Supplemental Items--A CAHPS survey is not planned for the state's elderly and/or physically disabled populations at this time; however, the state will continue to monitor national movement for LTSS satisfaction surveys and reserves the right to implement a CAHPS or CAHPS-like survey at a later date.
• Screening for Clinical Depression and Follow-Up Plan: DELAYED IMPLEMENTATION, Tabled for CYE 2014.

LTSS-focused performance measures include:
• Timeliness of Initial SP Development.
• Initiation of Services (within 30 days). |

		The state requires MCOs to meet periodic reporting requirements to include the following contract deliverables include: • Case Management Plan (annually). • Cultural Competency Evaluation (annually). • Enrollee Appeal and Provider Claim Dispute Report (quarterly). • Enrollee Grievance Report (quarterly). • Medical Management Plan and Evaluation (annually). • Member/Provider Council Plan (annually). • Network Development and Management Plan (annually). • QM Plan and Evaluation (annually). • QM Reports (quarterly). • Service Gaps for Attendant Care, Personal Care, Homemaker and Respite Care (bi-annually). To monitor receipt of services, the state requires the MCOs to submit a Non-Provision of Services Logs monthly and quarterly to document when services are not provided as authorized. The state defines the term "critical services" as inclusive of tasks such as bathing, toileting, and dressing, feeding, and transferring to or from bed or wheelchair, and assistance with similar daily activities. A gap in critical services is defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the member. When a member experiences a gap in critical services, they are directed to submit the Critical Service Gap Report Form, which can be mailed to the MCO. The member is also encouraged to call the toll-free state line, the provider and/or MCO rather than mailing the Critical Service Gap Report form so that the service gap can be responded to more timely. In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the MCO to ensure that critical services are provided within 2 hours of the report of the gap.
6.	LTSS-Focused PIPs	None specified.
7.	Care Coordination	MCO case managers' responsibilities include: • Conducting ongoing monitoring of the services and placement of each member. • Visiting members in their place of residence every 180 days for members residing in NFs and every 90 days for members residing in the community. • Annually reviewing member handbook with the member or representative. • Reviewing the MCO's process for immediately reporting any unplanned gaps in service delivery. The MCO is required to initiate a SP for each member at the first visit with the member, within 12 business days of enrollment. The MCO case manager reviews and updates the SP at each visit with the member or when there is a change in the member's condition or recommended services.

| | | MCOs must identify and facilitate coordination of care for all members during changes or transitions between MCOs, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances may require additional or distinctive assistance during a period of transition. Policies or protocols have been developed to address these situations.

If a member is referred to and approved for long-term care, the MCO must coordinate the transition with the assigned long-term care facility provider to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition. |
|---|---|---|
| 8. | 24-Hour Back-Up | The state requires MCO's to develop a Contingency/Back-Up Plan during the initial service planning process for all members who will receive Attendant Care, Personal Care, Homemaker and/or Respite Care services (referred to as "critical services") in their own homes. In addition, the MCO's must review the plan quarterly and have it signed by the member or member's representative. The Contingency/Back-Up plan outlines the in-home service provided to the member, the member's service preference level (how quickly the member feels the service would need to be replaced if the scheduled caregiver did not show up), and actions the member, or the member's representative will take to report and resolve gaps. The SP also provides the telephone number for the state hotline and provider/MCO telephone numbers, which are available 24/7. |
| 9. | CI Reporting and Investigation | The MCO is required to track and trend member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
• Acknowledgement letter to the originator of the concern.
• Documentation of all steps utilized during the investigation and resolution process.
• Follow-up with the member to assist in ensuring immediate health care needs are met.
• Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and an MCO contact name/telephone number to call for assistance or to express any unresolved concerns.
• Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern.
• Analysis of the effectiveness of the interventions taken. |
10.	Mortality Review	Mortality reviews are conducted on IDD member deaths by the MCO. The MCO for this population is the state's Division of Developmental Disabilities.
11.	EQRO Responsibilities	The state does not utilize the EQRO beyond the mandatory activities specified in CFR 438.
12.	Ombudsman/ Function	The MCO is required to have a Dispute and Appeal Manager who manages and adjudicates member and provider disputes including member grievances, appeals and requests for hearing and provider claim disputes.

13. Experience of Care/ Satisfaction Surveys	Since its inception in the late 1980s, the state has conducted a limited number of comprehensive ALTCS member satisfaction surveys. The most recent survey was conducted in 2008 with elderly and physically disabled members. The state is currently developing a comprehensive HCBS member satisfaction survey. Beginning in calendar year 2014 the MCO contracts require that the MCOs perform an annual survey of ALTCS members including questions related to case manager performance, waiting time for appointments, transportation wait times and culturally competent treatment of members. MCOs must use personnel other than case managers to administer the survey. Targeted surveys are also conducted with a limited number of ALTCS members in conjunction with the OFR process.
14. Membership Oversight	Venues for suggestions and feedback, such as public forums, member councils, and meetings with MCOs and providers, are regularly sponsored by the state. For the original Quality Strategy, as well as any subsequent substantive changes to the document, the state solicits input from the Director's State Medicaid Advisory Committee, which includes the Medicaid Director, representation from the American Indian community, MCO members, seniors, the disabled, and child advocacy communities, NF and HCBS advocates, the medical community (physicians), the state's Department of Health Services and the Department of Economic Security. These meetings are open are regularly attended by citizens, in addition to Council members.

MCO members also play a role in quality oversight by completing the Critical Service Gap Report Form. This mail-in form provides an opportunity for members to report a critical service gap. |
15. State Technical Assistance to MCOs	The state has frequent communications with MCOs providing an ongoing forum for feedback and technical assistance. For example, annually, contractors submit their QM/Performance Improvement Plans and Evaluations of the previous year's activities, UM Plans and Evaluations, PIP proposals and reports. The state's Clinical QM team coordinates a review of all these plans with other units within the state. After they review and analyze them along with the MCO's quarterly reports, they meet with the MCO to review any outstanding issues and use this opportunity to provide technical assistance.
16. MCO Report Cards on LTSS	None specified.
17. Financial Incentives, Penalties and Withholds	The state has not employed financial incentives. However, they are participating in a CHCS initiative that focuses on developing P4P programs in Medicaid. The programs under consideration focus on diabetes care, asthma, and care provided in nursing homes. Funding for the P4P programs was on hold due to state budget constraints.

18. Other Quality Management/ Improvement Activities	The state has an immediate jeopardy process that activates MCO staff when a significant health or safety issues is identified in a placement setting. MCOs are required to go on-site upon notification to conduct health and safety evaluations and take whatever action is necessary to ensure the safety of members. The state routinely communicates to MCOs the occurrence of adverse quality events that may have system-wide implications, so that the MCOs can address these issues in the spirit of QI. Review of reports and other date sometimes lead the state to conduct mini-audits to understand the reasons for data variances. These activities provide the state with information that may lead to corrective action plans and/or policy changes.

ADDS = Arizona Data Decision Support System
ADL = activity of daily living
AHCCCS = Arizona Health Care Cost Containment System
ALTCS = Arizona Long-Term Care System
CAHPS = Consumer Assessment Health Care Providers and Systems

CFR = Code of Federal Regulations
CHCS = Center for Health Care Strategies
CI = critical incident
CMO = Chief Medical Officer
CMS = Centers for Medicare and Medicaid Services

EQRO = external quality review organization
GSA = geographic services area
HCBS = home and community-based services
IDD = intellectual and developmental disabilities
IT = information technology

LTSS = long-term services and supports
MCO = managed care organization
MLTSS = managed long-term services and supports
NF = nursing facility
OALS = Arizona Office of Administrative Legal Services

OFR = Operational and Financial Reviews
P4P = pay-for-performance
PIP = performance improvement project
PMMIS = Pre-Paid Medical Management Information System
QI = quality improvement

QM = quality management
SP = service plan
UM = utilization management

APPENDIX B. MICHIGAN'S MANAGED SPECIALTY SUPPORTS AND SERVICES

Element	Description
MLTSS Program	Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
Lead Agency	Michigan Department of Community Health (MDCH)
Medicaid Authority	1915(b) Specialty Services Waiver 1915(c) Habilitation Supports Waiver
Inception	1998 for 1915(b)--serving persons with mental illness and DD. 2002 for 1915(c)--provides additional services (private duty nursing and goods/services), for subgroup of DD population.
Year LTSS Added	From inception.
Groups Enrolled	Persons with Mental Illness, DD and Dually Diagnosed.
# Enrolled	172,527 Data Source: *Section 404(1): Community Mental Health Services Support Programs Report*, May 31, 2013.
1. State Quality Oversight Infrastructure	The Division of Quality Management and Planning (within the Behavioral Health and Developmental Disabilities Administration, Bureau of Community Mental Health Services, MDCH) is the entity responsible for quality oversight of the program. This Division is comprised of 3 sections: • Data Section: Responsible for receiving and analyzing Performance Indicator data from the 18 PIHPs[27,28]--the MCO entities with which Michigan contracts and oversees the EQRO contract. Three staff is assigned to this section. • Service Innovation Section: Responsible for providing technical assistance to the PIHPs. Eight Program Specialists comprise this section. • Federal Compliance Section: Responsible for overall management of the MLTSS program, for PIHP site reviews, and for analysis of quality data. Once fully staffed, this section will have 8 staff members. The PIHPs are certified by the MDCH. If a PIHP (or subcontractor) is accredited by the Joint Commission, CARF, the Council on Accreditation, certification may be granted for up to 3 years but the MDCH also conducts a limited review of the agency. All must be licensed or accredited. Licensing is conducted by the Department of Licensing and Regulatory Affairs which shares licensing findings with the Behavioral Health and Developmental Disabilities Administration.

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[27] The state legislature mandated that as of October 1, 2013, the number of PIHPs will be reduced to ten new regional entities for simplification and equity statewide and to prepare mental health and developmental disability systems for increased integrated care approaches.

[28] The PIHPs must also be a designated Community Mental Health Services Program.

Element	Description
	Residential providers are certified by the MDHS. Problems identified by MDHS are forwarded to the MDCH for follow-up. A Behavior Treatment Review Committee is charged with reviewing and approving/disapproving any plans that propose to use restrictive or intrusive interventions with individuals served by the public MH system (including beneficiaries in this program) who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm.
2. State IT Infrastructure for Supporting Quality Oversight	PIHPs transmit limited quality-related data to the state via the state's Data Exchange Gateway and much of it is stored in MDCH's data warehouse. State staffed voiced frustration that the ability to share electronic health records between/among providers, PIHPs and the state does not yet exist. However, there is an ongoing pilot where a handful of PIHPs and Health Plans (MCOs for medical services) are sharing data. By sharing the data, they are able to examine high utilizes of hospital emergency departments for SA users. As of May 2013, only demographic, diagnostic and utilization information had been included as part of the data exchange, but the plan is to also populate the system with care plan information. This system is envisioned as the back-bone of "Care Bridge" for the Duals Demonstration.
3. MCO Quality Oversight Responsibilities	PIHP contracts with the state require them to develop and implement a QAPIP. A designated senior official of the PIHP must assume responsibility for the QAPIP implementation. PIHPS are accountable to a Community Mental Health Services Program Board of Directors for oversight of their QAPIP. Contracts entered into by the PIHPs with providers must address how quality will be monitored. Also, it is incumbent upon the PIHP to monitor providers and care coordinators on site annually; the state does not dictate the format or scope of the review, but delegates this to the PIHP. PIHPs' contract requires them to have a MIS that has capability to track grievances and complaints, quality indicator reporting and information on program participant access and satisfaction. PIHPs are required to verify that services reimbursed by Medicaid were actually furnished to enrollees by a provider. The PIHP's verification methodology must be approved by the state. The PIHP must annually submit its findings from this process and include in its report any follow-up actions that were taken as a result of the findings.
4. State Audits of MLTSS Program	The state conducts biennial on-site reviews of each PIHP. On alternate years, the site visits the PIHP to validate implementation of corrective action plans from the previous year's review. If, during a site visit, the state discovers a problem that requires immediate action then the PIHP must develop and implement and plan of correction in a shorter timeframe (specified by the state). In these instances the state will conduct validation in a shorter timeframe as well. In addition, if a problem is discovered on the 1915(c) habilitation waiver, then the PIHP must remediate the problem, within 90 days following the state's issuance of a findings report.

Element	Description
	The state's on-site reviews include clinical record review (random sample)--some with notice to the state which records will be pulled. However the state review team also selects a portion of the records while on site with no advance notice to the PIHP. The review team oversamples persons deemed "at risk" (i.e., in 24-hour supervised settings and those recently leaving such settings). The record review during site reviews include focus on whether the sampled individual received services in amount, scope and duration specified in SP. The state requires the PIHP to address (remediate) any problems in beneficiaries not receiving services as delineated in their services plans, but remediation is only tracked and reported for persons served under the 1915(c) habilitation waiver. A random proportionate sample of 367 records across 2 years (169 one year, 200 the next.) is drawn for persons served by the 1915(c) habilitation waiver. The sample is proportionate to the distribution of persons in the waiver in each PIHP.) The sample for individuals served under the 1915(b) authority is much smaller; the state reports that it reviews enough records to know if there is a systems-level problem and the PIHP concurs; additional records are pulled and added to the sample if the state believes there is a systems-level problem and has not achieved acknowledgement from the PIHP that a problem exists. The team also conducts interviews with a sample of persons (4-5 beneficiaries) included into the record review sample; they interview protocol focuses on person-centered planning, self-determination arrangements and individual budgets, access to transportation, satisfaction with services, among other topics. During the site review the state also reviews how the PIHP is monitoring their provider network. During the certification process for Community Mental Health Centers the PIHPs provider monitoring is also reviewed (certification review occurs every 3 years). PIHPs are required to submit a plan of correction within 30 days that addresses each review dimension for which there was a finding of partial or non-compliance. The state conducts an on-site follow-up the following year to verify corrective actions were implemented. If a PIHP receives a repeat citation on a site review dimension, the state site review team may increase the size of the clinical record review sample for that dimension for the next site review and/or require the program to re-undergo state approval to operate. Reports are shared with Bureau's management team and QIC. Information is used to take contract action or for making recommendations for system improvements. The state also conducts administrative reviews using multiple sources of information in tandem to identify potential quality issues (e.g., performance indicators, encounter data, grievance and appeal tracking, sentinel events reports, complaints, etc.).

Element	Description
5. Performance Measures and Quality-Related Reports	This program requires PIHPs to submit multiple performance indicators in the areas of access, adequacy, appropriateness, effectiveness, outcomes, prevention and structure/plan management. These performance indicators comprise the Michigan Mission-Based Performance Indicator System. The vast majority of the indicators are reported by the PIHPS in the aggregate. The state is moving toward generating the indicators themselves from data in the Department's data warehouse. Bulk of PI reported in aggregate from PIHPs. State would like to generate the PIs themselves since PIHPs. Use data warehouse for this. Standards that the PIHP is expected to achieve are associated with several of these indicators. If the PIHP does not meet a performance indicator standard it will be required to implement a plan of correction which the EQRO will review the following year for compliance. The state is considering building a financial withhold into future contracts for below-standard performance EQRO will look at this, validate it, EQRO does plan of correction, and EQRO follows up a year later on the PIHPs compliance with plan of correction. Performance Indicator results rare reviewed by both the Bureau of Mental Health Services' management team and the QIC.[29] Negative outliers in more than 2 consecutive periods are the focus of investigation. <u>Michigan Mission-Based Performance Indicator System Measures</u> are represented immediately below, organized by domain: **ACCESS PERFORMANCE MEASURES** • The percent of all Medicaid adult and children beneficiaries receiving a pre-admissions screening for psychiatric inpatient care for whom the disposition was completed within 3 hours. **Standard = 95% in 3 hours**. • The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service--MI adults, MI children, DD adults, DD children, and Medicaid SA. **Standard = 95% in 14 days**. • The percent of new persons starting any needed ongoing service within 14 days of a non-emergent assessment with a professional--MI adults, MI children, DD adults, DD children, and Medicaid SA. **Standard = 95% in 14 days**. • The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within 7 days--All children and all adults (MI, DD) and all Medicaid SA (sub-acute detox discharges). • The percent of Medicaid recipients having received PIHP managed services--MI adults, MI children, DD adults, DD children, and SA. **ADEQUACY/APPROPRIATENESS PERFORMANCE MEASURES** • The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least 1 HSW service per month that is not supports coordination.

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[29] The QIC is a stakeholder group comprised of consumers, advocates, provider organizations, PIHPs and Community Mental Health Service Programs.

Element	Description
	EFFICIENCY PERFORMANCE MEASURES • The percent of total expenditures spent on managed care administrative functions for PIHPs. **OUTCOMES PERFORMANCE MEASURES** • The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with DD served by PIHPs who are in competitive employment. • The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with DD served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop). • The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days. • The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II. • The percent of adults with DD served, who live in a private residence alone, or with spouse or non-relative. • The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative. • The percent of children with DD (not including children in the Children's Waiver Program) in the quarter who receive at least 1 service each month other than case management and respite. In addition to the Michigan Mission-Based Performance Indicators, the state also requires the PIHP to submit additional measures: • PIHPs must meet a standard of 100% whereby people who meet the OBRA Level II Assessment criteria for specialized MH services for people residing in nursing homes, as determined by MDCH shall receive PIHP managed MH services. • An increased number of Medicaid children (birth through age 17 years) with SUD per 1,000 in the PIHP service area who are provided Medicaid SA specialty services and supports. • An increased number of Medicaid adults (age 18 and older) with SUD per 1,000 in the PIHP service area who are provided Medicaid SA specialty services and supports. • An increased percentage in FY 2011 Medicaid expenditures over the base year of FY 2006 Medicaid expenditures for children and adults with SUD.

Element	Description
	For the following measures each PIHP must negotiate its individual performance targets. A baseline for FY 2006 will be established. For FY 2008 no sanctions will be imposed for failure to reach target. In future years, P4P will be imposed, with the details of the P4P arrangement negotiated between MDCH and the PIHP and included in subsequent contract amendments. • An increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who are provided Medicaid MH specialty services and supports. • For children with: (a) SED; and (b) DD/SED co-occurring conditions, an increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who are provided Medicaid MH specialty services and supports. • For children with DD, an increased number of Medicaid children per 1,000 Medicaid-eligible children in the PIHP service area who receive MH specialty services and supports. In addition to these measures, the state also develops and reports to CMS performance measures as agreed upon in its approved waiver for the 1915(c) habilitation waiver. These measures are responsive to the 1915(c) assurances and sub-assurances.
6. LTSS-Focused PIPs	Because the population in the program is, by definition, the LTSS population, all PIPs focus on the LTSS population. The state identifies PIPs for each waiver based on analyses of quality data, EQRO findings and stakeholder concerns. All PIHPs must conduct a minimum of 2 PIPS during a waiver cycle. All PIHPs conduct 1 mandatory 2-year PIP assigned by the state. PIHPs are allowed to choose the second PIP, unless a PIHP is having difficulty in a given area, then the state may assign the second PIP relevant to the area of concern. Semi-annually PIHPs report to the state on their PIP's progress, which is reviewed by the state and the QIC. In FY 2012-2013, the state-mandated PIP is targeted to Increasing the proportion of Medicaid-eligible adults with mental illness who receive at least 1 peer-delivered service or support.
7. Care Coordination	Supports Coordination is a service that most members choose. Targeted case management is also available for persons experiencing acute MH episodes. Care coordinators may be employed by the PIHP/CMH or a provider agency within the PIHP network; and there are independent supports coordinators as well.

Element	Description
	For the DD clients care coordination tends to typically include assessment, service planning, and monitoring service provision. However for members receiving behavioral health services care coordination for persons with chronic mental illness is less constant and tends to focus on assistance with housing and linkages to community services. Rather than the care coordinator being the person with whom the member has the primary relationship, behavioral health members tend to have that primary relationship with their counselor or a peer support specialist. Supports coordinator cannot make utilization determinations-- amount/scope/duration. Supports coordinator help develop SPs, but cannot approve amount/scope/ duration of services. A utilization manager at PIHP is responsible for authorizing services; in some instances the utilization review function may be delegated to a "super-provider" or the Community Mental Health Center. The care coordinator is responsible for updating SPs on annual basis for person enrolled in the 1915(c) waiver, as well as when the person's needs change. In the 1915(b) waiver, the SP must only be revised when the person's needs change. Care coordinator contacts with members vary depending on need. For more intense need monthly contacts are recommended, but not required. Amount, scope and duration of care coordination are specified in the SP. There are no caseload requirements.
8. 24-Hour Back-Up	PIHPs are required to provide emergency and after-hours access to services for persons experiencing a MH emergency.
9. CI Reporting and Investigation	CI Reporting System. PIHPs must report 5 CIs to the state via the state's CI reporting site on the state's website: • Suicide; • Non-suicide death; • Emergency Medical treatment due to Injury or Medication Error; • Hospitalization due to Injury or Medication Error; • Arrest of Consumer. CIs must be reported within 60 days after the end of the month in which the event occurred, except for suicide. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. PIHPs must notify the state immediately of deaths that occur as a result of a suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. Reports must be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced.

Element	Description
	The PIHP or its delegate is responsible for implementing the process of the review and follow-up of sentinel events. And other CIs and events that put people at risk of harm. The PIHP or its delegate has 3 business days after a CI occurs to determine if it is a sentinel event. If the CI is classified as a sentinel event, the PIHP or its delegate has 2 business days to commence a root cause analysis of the event. Persons involved in the review of sentinel events must have the appropriate credentials.

The state reviews CI data on a monthly basis then rolls it up into quarterly reports for trend analysis.

Abuse, Neglect and Exploitation. Two other entities within the state receive reports on abuse, neglect and exploitation--the Office of Recipient Rights (within the MH system) and Adult Protective Services (MDHS). Multiple entities could be involved in investigations, including law enforcement.

Risk Event Management. The PIHP must have a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The state will request documentation of this process when performing site visits. These events include:
- Actions taken by individuals who receive services that cause harm to themselves.
- Actions taken by individuals who receive services that cause harm to others.
- Two or more unscheduled admissions to a medical hospital within a 12-month period.

Restrictive Interventions. On a quarterly basis, the PIHP is required to review data from a Behavior Treatment Review Committee (which is part of the local MH agency) where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement has been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data must include:
- Dates and numbers of interventions used.
- The settings (e.g., individual's home or work) where behaviors and interventions occurred.
- Observations about any events, settings, or factors that may have triggered the behavior.
- Behaviors that initiated the techniques.
- Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
- Description of positive behavioral supports used.
- Behaviors that resulted in termination of the interventions.
- Length of time of each intervention.
- Staff development and training and supervisory guidance to reduce the use of these interventions.
- Review and modification or development, if needed, of the individual's behavior plan. |

Element	Description
10. Mortality Review	PIHPs are required to conduct mortality reviews as part of their QAPIP. According to the PIHP's contract, they are required to review all unexpected deaths (suicides, homicides, deaths experienced by person having an undiagnosed condition, accidental deaths, deaths where there is suspicion of abuse or neglect). Reviews must include: • Screens of individual deaths with standard information (e.g., coroner's report, death certificate). • Involvement of medical personnel in the mortality reviews. • Documentation of the mortality review process, findings, and recommendations. • Use of mortality information to address quality of care. • Aggregation of mortality data over time to identify possible trends.
11. EQRO Responsibilities	EQRO monitors the PIHP's implementation of its QAPIP during an on-site review. The EQRO reviews. If any deficiencies are found, the EQRO works with the PIHP to develop and implement performance improvement activities, and is responsible for validating they have been implemented.
12. Ombudsman/ Function	PIHPs must have Customer Services unit to: • Welcome and orient individuals to services and benefits available, and the provider network. • Provide information about how to access MH, primary health, and other community services. • Provide information about how to access the various rights processes. • Help individuals with problems and inquiries regarding benefits. • Assist people with and oversee local complaint and grievance processes. • Track and report patterns of problem areas for the organization.
13. Experience of Care/ Satisfaction Surveys	PIHPs are required to conduct an annual survey of adults with mental illness using the MHSIP. This is a mail survey using a convenience sample of individuals who receive services during 1 month of the year. The state is collecting data using the National Core Indicators to survey DD members. This effort is funded under a 1-year grant by the federal Administration for Community Living. The state would like to sustain this effort but finding state funds to continue may be problematic. The state is drawing a random sample across its DD system and using local ARC chapters and CMHC staff for data collection.
14. Membership Oversight	The QIC comprised of consumers, advocates, provider organizations, PIHPs and Community Mental Health Service Programs meets regularly to review quality reports. During the state's biennial PIHP on-site reviews focus groups are conducted with consumers, advocates, providers and other community stakeholders to elicit evaluation of the PIHP's progress implementing initiatives such as person-centered planning, self-determination, employment, recovery, rights, etc. as well as involvement of beneficiaries and stakeholders in the QAPIP.
15. State Technical Assistance to MCOs	Program Specialists in the state's MDCH provide technical assistance to the PIHPs on quality.
16. MCO Report Cards on LTSS	None specified.

Element	Description
17. Financial Incentives, Penalties and Withholds	The state offered a financial incentive to the PIHPs for increasing self-determination arrangements. Self-report data was submitted by the PIHPs for consideration of the award. However; the state had no mechanism for independently confirming the data from PIHPS. This incentive was only offered for 1 year. Currently, the PIHPs are eligible for first and second place monetary award who has shown a relative improvement over the last fiscal year in the following areas: • Overall number of consumers engaged in meaningful employment. • Overall number of consumers served that are living in a private residence not owned by the PIHP or the contracted provider, either alone or with spouse or non-relative. • Overall numbers of enrollees discharged from a SA detox unit and seen for follow-up within 7 days. In order to be eligible for the award, a PIHP must not have received a non-compliance score for any site review dimension in their site review report. The state characterized these as modest financial incentives: $30,000 for first place and $25,000 for second place. The incentives are so modest some PIHPs said it was not worth their while to participate. The PIHP contract specifies that financial sanctions may be imposed to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance on performance indicator standard, repeated site review non-compliance, substantial inappropriate denial of services, or substantial or repeated health and/or safety violations. In the next contract (January 2014), the state intends to include withholds for poor performance.
18. Other Quality Management/ Improvement Activities	"Creating a Culture of Gentleness" is training efforts to improve the skills of direct care workers and supervisors in the support of people with DD who have behaviors that put themselves or others at risk of harm. Over 2,700 staff has been trained. MDCH was looking to expand the program to increase training statewide.

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

LTSS = long-term services and supports
MCO = managed care organization
MDCH = Michigan Department of Community Health
MDHS = Michigan Department of Human Services
MH = mental health

MHSIP = Mental Health Statistics Improvement Program
MI = mentally ill
MIS = Management Information System
MLTSS = managed long-term services and supports
P4P = pay-for-performance

PIHP = Pre-paid Inpatient Health Plan
PIP = performance improvement project
QAPIP = Quality Assessment and Performance Improvement Plan
QIC = Quality Improvement Council
SA = substance abuse

SP = service plan
SUD = substance use disorder

APPENDIX C. MINNESOTA SENIOR CARE PLUS AND MINNESOTA SENIOR HEALTH OPTIONS

Element	Description
MLTSS Program	Minnesota Senior Care Plus (MSC+) Minnesota Senior Health Options (MSHO)
Lead Agency	Minnesota Department of Human Services
Medicaid Authority	MSC+: 1915(b)/(c) MSHO: 1915(a)/(c)
Inception	MSC+: 2005 MSHO: 1997
Year LTSS Added	From inception.
Groups Enrolled	MSC+: Elderly. MSHO: Elderly eligible for both Medicaid and Medicare Parts A & B.
# Enrolled	MSC+: 13,120 (August 2013). MSHO: 35,739 (August 2013).
1. State Quality Oversight Infrastructure	The state utilizes the single state Medicaid agency (Department of Human Services) and the Department of Health to oversee 8 MCO plans for the MCS+ and MSHO programs. Within Medicaid, there are several entities that play a quality oversight role including monitoring of MCO contracts and program oversight, with 5 quality oversight staff dedicated to the project. The Department of Health licenses providers and conducts quality monitoring utilizing 4 staff.
2. State IT Infrastructure for Supporting Quality Oversight	The state relies on its MMIS for generating information on encounter data, claims data, diagnosis of members, MLTSS enrollment, eligibility information and screening data.
3. MCO Quality Oversight Responsibilities	The state requires MCOs to maintain and report annually on 2 quality oversight activities, adhering to NCQA's sampling standards, which are as follows: • **Care Plan Audit**--This protocol covers all the aspects of care plan development to ensure all policies and procedures are adequately followed. • **Care System Audit**--This protocol is broader and encompasses all aspects of the service delivery system. The audit reports generated from these protocols also include corrective actions taken by the MCO when issues of non-compliance are discovered. The annual reports are submitted to the state for review. These reports are then used as part of the state's evidence-based report for fulfilling the 1915(c) HCBS quality requirements. The State's Department of Health conducts "look-back" reviews of the audits 18 months after the MCO audits are completed to monitor remediation activities on any issues/deficiencies identified during the review.

Element	Description
4. State Audits of MLTSS Program	The state conducts a TCA, which is a validation of contract compliance done for each MCO. It involves a review of 16 elements that are used to evaluate the care given to members. This information is collected during its QA Examination, which is done every 3 years. During the on-site exam the state collects, validates and reports MCO compliance information. The state then develops a summary of the information gathered for the 16 elements of the TCA, including: • Coverage of services; • Accessibility of providers; • QI program structure; • UM; • Special health care needs; • Practice guidelines; • Credentialing/Re-credentialing; • Annual QAPIP evaluation; • PIPs; • DM; • MCO grievances process requirements; • DTR notice of action to enrollees; • MCO appeals process requirements; • Advance directives compliance; • MCO care plans for MSHO and MSC+; • Information system. Between the TCA, the state conducts follow-up visits approximately 1.5 years from the TCA to monitor the MCO's progress on resolving any issues discovered during the tri-annual audit. The state holds a group meeting with the MCOs monthly to discuss operations and monitoring.
5. Performance Measures and Quality-Related Reports	The state utilizes the Care Plan Audit protocol which contains approximately 30 performance measures (mostly process-oriented measures). The sampling methodology used for the Care Plan Audit is the NCQA-approved 8 and 30 process. In addition to the Care Plan Audit, the state also compares NF versus community placement to monitor NF admissions. This is monitored at both the system-wide level and the MCO level.
6. LTSS-Focused PIPs	The state does not require MCOs to conduct LTSS-focused PIPs.
7. Care Coordination	The state utilizes a multi-entry system for individuals to receive an initial LOC (i.e., the initial LOC evaluation can be conducted by the MCO, a subcontractor or the county). The LOC is re-determined annually. The initial assessment and the ongoing assessments are conducted by the Care Coordinator. MCOs use a state-defined assessment tool, however they are permitted to add additional questions. Care Coordinators also develop the SPs using a holistic, person-centered approach. The state does not require a specific care coordinator-member ratio, however each MCO is required to develop a methodology for how they determine their care coordinator-member ratio and submit to the state for approval.

Element	Description
	The MCO must provide Care Coordination services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post-acute and rehabilitation services. The MCO's Care Coordination system must be designed to ensure communication and coordination of an enrollee's care across the Medicare and Medicaid provider network and settings, to accomplish smooth transitions for enrollees who move among various settings, as well as to facilitate and maximize the level of enrollee self- determination and enrollee choice of services, providers and living arrangements. The MCO must provide each enrollee with a primary contact person who will assist in access to services and information.
8. 24-Hour Back-Up	At the individual level, the Care Plan must include identification of any risks to health and safety and plans for addressing these risks, including Informed Choices made by members to manage their own risk, and back-up plans for emergency situations. At the systems level, each MCO must have a 24/7 nurse hotline for members to access.
9. CI Reporting and Investigation	The state mandates that the local county social services agencies accept reports of maltreatment, provide emergency protective services and investigate maltreatment allegations. MCO address incidents of self-neglect.
10. Mortality Review	The state selectively conducts mortality reviews in its MLTSS programs.
11. EQRO Responsibilities	EQRO responsibilities include: • Assessing each contracted MCO's strengths and weaknesses with respect to quality, timeliness and access to health care services. • Providing recommendations for improving quality of services furnished by each MCO. • Providing appropriate comparative information about all MCOs. • Assessing the degree to which each MCO has addressed problems and effected changes as previously identified by the state. Minnesota Department of Human Services or as recommended by the EQRO. • Evaluating the implementation and effectiveness of the Quality Strategy. • Advising the state on opportunities for improvement. Annually, the EQRO conducts the 3 mandatory quality review activities: • Validation of PIPs. • Validation of performance measures. • MCO compliance with Medicaid structure and operational standards.
12. Ombudsman/ Function	The state has established a state Office of the Ombudsman for managed care enrollees. MCO enrollees are informed by their care coordinator about the state Office of the Ombudsman and its functions at their initial visit and subsequently at annual visits. When a service is denied, terminated, or reduced, the MCO must give the enrollee a notice of action including a description of the enrollees' rights with respect to MCO appeals and state Fair Hearing process. On a quarterly basis, MCOs submit specific information about each notice of action to the state Ombudsman Office. This office reviews this information, and tracks and trends DTRs.

Element	Description
13. Experience of Care/ Satisfaction Surveys	The state administers a bi-annual consumer survey to persons aged 65 and older who are enrolled in the state's MLTSS and HCBS FFS programs. The survey was designed by the state's aging division and is based on the PES. The state draws a random sample from the entire LTSS population. Survey results are disseminated to lead agencies and any specific issues revealed as a result of the survey are forward to the responsible county for resolution.
14. Membership Oversight	Each MCO must have a Member Advisory Committee which must meet regularly. Minutes from each meeting are submitted to the state to demonstrate how the issues discussed during the meeting are addressed.
15. State Technical Assistance to MCOs	The state engages in technical assistance to the MCOs through a variety of forums including: • Workgroups; • Monthly meetings with MCOs; • Video conferences with MCOs. The state also provides targeted technical assistance to an individual MCO if the state detects plan-specific issues through the audits, grievances or complaints, or from communication with the managed care ombudsman program.
16. MCO Report Cards on LTSS	The state does not utilize MCO report cards.
17. Financial Incentives, Penalties and Withholds	The state withholds a portion of MCO payments which are returned to the MCO only if performance targets are achieved. The withheld funds are returned to the MCO based on a scoring system for each of the performance targets including: • Specific provider measures. • Completion and submission of the Care Plan audit. • Timely completion of initial health risk screening or assessments. In addition, the MCO is required to cooperate with the state to develop and implement a P4P model for chronic disease care. The state pays the monetary incentives to the MCO based on criteria established by the state. The MCO, in turn, conveys payments to its provider network, based on having achieved optimal chronic disease care for a designated percentage of its patients. The P4P projects are limited to diabetes care, and coronary/vascular disease care.
18. Other Quality Management/ Improvement Activities	MCOs collaborate on the development and implementation of PIPs. In the spirit of fostering a partnership with the MCOs, the state has implemented workgroups across MCOs to improve quality. These workgroups consist of state personnel and various staff from the MCOs including care coordinators, supervisors and auditors.

CI = critical incident
DM = disease management
DTR = denial, termination, and reduction
EQRO = external quality review organization
FFS = fee-for-service

HCBS = home and community-based services
IT = information technology
LOC = level of care

LTSS = long-term services and supports
MCO = managed care organization

MLTSS = managed long-term services and supports
MMIS = Medicaid Management Information System
MSC+ = Minnesota Senior Care Plus
MSHO = Minnesota Senior Health Option
NCQA = National Committee on Quality Assurance

NF = nursing facility
P4P = pay-for-performance
PES = Participant Experience Survey
PIP = performance improvement project
QA = quality assurance

QAPIP = Quality Assessment and Performance Improvement Plan
QI = quality improvement
SP = service plan
TCA = Triennial Compliance Assessment
UM = utilization management

APPENDIX D. NORTH CAROLINA'S 1915(b)/(c) MEDICAID WAIVER FOR MENTAL HEALTH/ DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

Element	Description
MLTSS Program	North Carolina 1915(b)/(c) Medicaid Waiver for MH/DD/SAS
Lead Agency	Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA)
Medicaid Authority	1915(b)/(c)
Inception	2005
Year LTSS Added	An MLTSS program from inception.
Groups Enrolled	Persons with Mental Illness, SA Disorders and IDD.
# Enrolled	1,426,398--total number enrolled. 84,861--using MH, DD or SAS (breakout by disability group currently not available).
1. State Quality Oversight Infrastructure	For quality oversight, North Carolina's Waiver relies on the Behavioral Health Unit in the DMA and the staff responsible for services for individuals with intellectual and/or DD housed in the operating agency, the DMH/DD/SAS. DMA's Behavioral Health Unit has 4 contract managers at the state level that oversee the operations and quality of 11 LME-MCOs. These contract managers are also responsible for staffing an IMT that meets at least quarterly to review Performance Indicators, reports and data, and timeliness of submission of reports from the LME-MCOs. The DMA contract managers lead the IMT, in collaboration with the operating agency for intellectual and DD services, DMH/DD/SAS. The IMT includes representatives from quality, finance, information systems and clinical services from DMA, DMH/DD/SAS and from the LME-MCO. The DMA Behavioral Health unit also has 1 FTE that is dedicated to quality at the state level. This staff member oversees the contract for the EQRO, the quality strategy and all quality reporting. Additionally, there is state level stakeholder oversight provided by the DWAC. This is an advisory body to DHHS that provides input and consultation over implementation and operational phases of the 1915(b)/(c) Medicaid waivers and the ongoing LME-MCO operations (Medicaid managed care, Innovations and LME operations).
2. State IT Infrastructure for Supporting Quality Oversight	The state is currently revamping its IT system to meet the needs of operating a managed care system and requires each LME-MCO to make all collected data available to the state and, upon request, to CMS. Until the state's MMIS is revised to accept and process encounter data, the LME-MCO must submit electronic records of encounters to DMA on an as-needed basis for rate-setting, QA, waiver amendments, renewals, EQRO activities and other activities as required by DMA. The state expects each LME-MCO to submit encounter reports that include all capitated data, for all services rendered under the (b) and (c) waivers.

Element	Description
3. MCO Quality Oversight Responsibilities	LME-MCOs are required to employ a full-time QM Director with appropriate qualifications including QM experience and managed care experience or experience in MH, DD and SA care. The LME-MCOs also monitor services provided by network providers. This includes conducting peer review activities such as identification of practices that do not meet standards, recommending corrective actions and monitoring provider corrective actions. LME-MCOs are also required to verify that services reimbursed by Medicaid were actually furnished to enrollees by a provider. This occurs through case record reviews. The LME-MCOs submit their findings from case record reviews to the state on an annual basis. The LME-MCOs also measure provider performance through the Gold Star Monitoring process. This is a mechanism to monitor provider agencies and licensed independent practitioners. Agencies are monitored in the following areas: • Implementation and compliance with the core rules for the delivery of MH/IDD/SAS. • Protection of the individual's rights. • Safeguarding the health, safety and well-being of individuals receiving services. • Staff qualifications. • Compliance with documentation requirements. • Medication management. • Cultural competency. • Requests to add a new service. • Non-contract providers. • Integrity of billing through post-payment reviews. Licensed independent practitioners are monitored via the following: • An on-site review to evaluate the practice site in terms of accessibility, recordkeeping, the presence of safeguards to assure confidentiality and compliance with HIPAA privacy and security regulations. • Record reviews to assess the extent to which technical assistance is needed to ensure state standards for documentation are met and that the documentation is adequate to support billing. • Post-payment reviews to evaluate the integrity of billing. • A review of practitioner's implementation of a cultural competency plan.

Element	Description
4. State Audits of MLTSS Program	DMA and DMH/DD/SAS conduct joint Annual Monitoring Reviews on-site at LME-MCOs. The Monitoring Reviews include but may not be limited to a review of: • LME-MCO's compliance with the requirements of this contract. • LME-MCO's compliance with state and federal Medicaid requirements. • LME-MCO's compliance with N.C.G.S. 122C-112.1. To the extent possible, the review does not duplicate areas assessed by the National Accrediting Body (once LME-MCO accreditation has been achieved). Thus far, Monitoring Reviews have been led by an external consulting group to ensure that LME-MCOs are having sufficient resources in place to provide managed care services.
5. Performance Measures and Quality-Related Reports	North Carolina collects a number of HEDIS and HEDIS-like performance measures include the following: • Follow-up after hospitalization for mental illness. • Readmission Rates for MH. • Readmission Rates for SA. • Ambulatory follow-up within 7 calendar days of discharge for SA therapy. • Ambulatory follow-up within 7 calendar days of discharge for MH. • Initiation and engagement of alcohol and other drug dependence treatment. • MH Utilization--Inpatient discharges and average length of stay. • MH Utilization--Percentage of members receiving inpatient, day/night care, ambulatory and other support services. • Chemical Dependence Utilization--Inpatient discharges and average length of stay. • Chemical Dependency Utilization--Percentage of members of receiving inpatient, day/night care, ambulatory and other support services. • Integrated care. • Identification of alcohol and other drug services. • Call answer timeliness. • Call abandonment. • Payment (authorization) denial. • Out of network service. • Network capability. • Unduplicated count of Medicaid members. • Race/ethnicity diversity of membership.
	North Carolina has also developed several performance measures that are a requirement of the assurances and sub assurances associated with the Medicaid 1915(c) program. Performance measures for a (c) waiver participant include measures addressing: • Health and safety; • Choice; • Quality of the SP; • Provider remediation, compliance, standards, enrollment and capacity; • LOC process and instrument; • Slot transfer and tracking. LME-MCOS must also provide quarterly reports on: • Grievances and complaints; • CIs.

Element	Description
6. LTSS-Focused PIPs	Because the population in the program is, by definition, the LTSS population, all PIPs focus on the LTSS population. The state requires the LME-MCOs to implement a total of 3 PIPs over the 2 years of the contract. During the first year, the LME-MCO is to implement 2 PIPS, 1 clinical and 1 non-clinical. Contractually determined appropriate topics for PIPs include: • Primary, secondary and/or tertiary prevention of acute mental illness conditions. • Primary, secondary and/or tertiary prevention of chronic mental illness conditions. • Care of acute mental illness conditions. • Recovery/outcome measures. • Care of chronic mental illness conditions. • High-volume services. • High risk services. • Continuity and coordination of care. • Availability, accessibility, and cultural competency of services. • Quality of provider/patient encounters. • Appeals and grievances.
7. Care Coordination	All members are assigned a care coordinator upon enrollment. The LOC assessment is conducted by the network provider and is submitted to the LME-MCO UM team. An ISP is developed by the provider and the provider reassesses the SP annually. Both the ISP and LOC are standardized.
8. 24-Hour Back-Up	There is currently no requirement for a 24-hour back-up system.
9. CI Reporting and Investigation	The LME-MCO must submit CI reports as part of ongoing statistical reporting.
10. Mortality Review	The LME-MCOs convene mortality reviews; however, they are not required to submit their findings to North Carolina DMA.
11. EQRO Responsibilities	North Carolina DMA contracts with an EQRO to conduct an annual independent EQR. The EQRO conducts 3 mandatory activities: • Determining LME-MCO compliance with federal Medicaid managed care regulations. • Validation of PMs produced by the LME-MCO. • Validation of PIPs undertaken by the PIHP. In addition, based on the availability of encounter data, the EQRO conducts encounter data validation. North Carolina DMA recently released a RFP for EQRO services expanding the role of the EQRO to include conducting a statewide consumer experience/satisfaction survey and validation of LTSS performance measures. Previously, only (b) waiver measures were validated by the EQRO.
12. Ombudsman/ Function	North Carolina presently does not have an ombudsman for MLTSS services for individuals with IDD. There is, however, a state level grievance and appeals center that is housed in the operating agency (DMH/DD/SAS). Data on grievances and appeals from the operating agency are shared in an annual report.

Element	Description
13. Experience of Care/ Satisfaction Surveys	Each plan (LME-MCO) is currently required to contract with an external vendor to conduct an annual satisfaction survey using an instrument approved by the state. Additionally, the state supports the collection of Core Indicators surveys for the IDD population.
14. Membership Oversight	Membership oversight is provided through state level stakeholder oversight provided by the DWAC. This is an advisory body to DHHS that provides input and consultation over implementation and operational phases of the 1915(b)/(c) Medicaid waivers and the ongoing LME-MCO operations (Medicaid managed care, Innovations and LME operations). DWAC membership includes the following: • 3 providers--2 local and 1 statewide. • 2 enrollees from state and local consumer advisory committees. • 3 enrollees who are not on the state or local consumer advisory committee, 1 from each disability group. • 1 member from the External Advisory Committee. • 2 members representing the county commissioners. • 2 members representing the LME-MCOs. • DMA director and chief commercial officer. • DMH/DD/SAS director and medical officer. • DHHS deputy director for health services.
15. State Technical Assistance to MCOs	Annual Monitoring and routine interactions with the state determine the need for technical assistance.
16. MCO Report Cards on LTSS	There are currently no MCO report cards.
17. Financial Incentives, Penalties and Withholds	There are currently no financial incentives or penalties. The program had instituted both financial incentives and penalties initially with the pilot 5 county program; however, these were removed when the program was mandated to expand statewide.
18. Other Quality Management/ Improvement Activities	None specified.

CI = critical incident
CMS = Centers for Medicare and Medicaid Services
DD = developmental disability/developmentally disabled
DHHS = North Carolina Department of Health and Human Services
DMA = North Carolina Division of Medical Assistance

DMH/DD/SAS = North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DWAC = Department Waiver Advisory Committee
EQRO = external quality review organization
FTE = full-time equivalent
HEDIS = Health Effectiveness Data and Information Set

HIPAA = Health Insurance Portability and Accountability Act
IDD = intellectual and developmental disabilities
IMT = Intra-departmental Monitoring Team
ISP = Individualized Service Plan

IT = information technology

LME = local management entity
LOC = level of care
LTSS = long-term services and supports
MCO = managed care organization
MH = mental health

MLTSS = managed long-term services and supports
MMIS = Medicaid Management Information System
PIHP = Pre-paid Inpatient Health Plan
PIP = performance improvement project
QA = quality assurance

QM = quality management
RFP = request for proposal
SA = substance abuse
SAS = substance abuse services
SP = service plan

UM = utilization management

APPENDIX E. PENNSYLVANIA'S ADULT COMMUNITY AUTISM PROGRAM

Element	Description
MLTSS Program	Adult Community Autism Program (ACAP)
Lead Agency	Pennsylvania Office of Developmental Programs, Bureau of Autism Services
Medicaid Authority	1915(a)
Inception	2009
Year LTSS Added	2009
Groups Enrolled	Adults with autism.
# Enrolled	134 (September 1, 2013)--1 MCO for ACAP.
1. State Quality Oversight Infrastructure	The state has a Program Director, a Clinical Director (also Directs other state programs), 2 ACAP Monitors and an Intake Enrollment Specialist. The ACAP team meets with the MCO on a monthly basis for full day meeting to keep communication open and to problem solve. Staff from the MCO includes the MCOs clinical directors, team leaders, and other approval staff as needed. The ACAP Monitors conducts a comprehensive on-site review of the ACAP on an annual basis to review overall quality in this program.
2. State IT Infrastructure for Supporting Quality Oversight	The state has an IT system to collect assessment and SP information for ACAP participants. The MCO is required to purchase the software and required licenses to allow for electronic communication and transfer of this information to the state. The state also has an automated CI reporting system that MCOs use to report CIs and actions taken to respond to incidents. The state is able to use these systems analyze participant information to monitor the performance of the MCO.
3. MCO Quality Oversight Responsibilities	The MCO is required to establish a Plan Advisory Committee to report to and advise the governing body on matters related to the complaint and grievance processes, QM, utilization review processes, and ethics. The Committee establishes, maintains, and provides support to a Complaint and Grievance Committee that is also accountable to the Governing Body. The Plan Advisory Committee reviews the MCO's procedures and makes recommendations for improvements. When the MCO or the state identifies deficiencies or areas for that need improving, the MCO and/or provider must take corrective action to ensure that the provider deficiencies are address and performance is improves. The MCO is required to: • Establish ongoing mechanisms to monitor provider compliance with the state's standard for timely access to care and services as specified. • Monitor the performance of providers on an ongoing basis by conducting a formal review of each provider at least annually and if any deficiencies or areas of improvement are identified, take corrective action or require the provider to take corrective action. • Detect both under utilization and over utilization of services to assess the quality and appropriateness of care furnished to all participants.

Element	Description
	The MCO is required to establish, maintain, and provide support to a Quality Management and Utilization Review Committee. The Committee provides guidance and assistance to support the MCO in carrying out the following responsibilities: • Developing mechanisms for collecting and evaluating information, identifying problems, formulating recommendations, disseminating information. • Implementing corrective actions, and evaluating the effectiveness of action taken. • Reviewing annually and making recommendations concerning the formulation, revision or implementation of the policies governing the scope of services offered, practice guidelines, medical supervision, ISPs, crisis intervention care, clinical records, personnel qualifications and program evaluation. • Providing technical advice regarding professional questions and individual service problems. • Participating in program evaluation including annual evaluation of the MCO's performance. • Assisting in maintaining liaison with professional groups and health providers in the community. • Participating in the development and ongoing review of written policies, procedures, and standards of patient care and QM. • Reviewing the adequacy and effectiveness of QM and utilization activities on a quarterly basis. • Developing mechanisms for evaluating responsiveness of the complaint and grievance processes and for collecting and analyzing information about voluntary disenrollment. The MCO must also ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.

Element	Description
4. State Audits of MLTSS Program	The state ACAP team meets with the MCO on a monthly basis for full day meeting to keep communication open and to problem solve. Topics for these meetings include concerns related to service utilization, employment, and problem solving related to specific participants. The state and MCO also discuss follow-up to monitoring, applicant referrals for enrollment, and assessment/SPs concerns. Staff from the MCO includes clinical directors, team leaders, and other staff as needed. The state ACAP monitors conduct a comprehensive on site review of ACAP on an annual basis to review the MCO's performance, develop specific quality goals, and establish of performance measurement criteria. The MCO must submit reports required by the state 2 weeks before it meets with the state. The state ACAP Monitors also meet with families and participants (approximately 15% of the ACAP participants) and complete satisfaction questionnaires during their annual review process. During the annual review process, the state also looks at psychotropic medications (chemical restraint) (i.e., look at participants who have 4 or more psychotropic meds). (The MCO is required to ensure that this be reviewed by doctor/pharmacy.) A findings report is sent to the MCO with a request for plans of correction if indicated. The state also discusses the results of their reviews during the monthly meetings held with the MCO. The state plays and active role in supporting the MCO to address gaps/issues identified.

5. Performance Measures and Quality-Related Reports	The state has established the following performance measures:
	• Fewer episodes of:
	  - Law enforcement involvement;
	  - Psychiatric inpatient and ER hospitalizations;
	  - MH crisis interventions;
	  - Law enforcement involvement;
	  - MH crisis interventions.
	• Increases in:
	  - Annual dental exams;
	  - In diabetes management;
	  - Annual gynecological exams.
	• Percentages of:
	  - Complaints received and resolved;
	  - Grievances received and resolved.
	• Experience of care:
	  - Increase in percentages of participants with jobs or volunteer opportunities;
	  - Participant satisfactions and quality of life indicators.
	• The MCO is required to submit quarterly reports that include the following information:
	  - Number of participant deaths;
	  - Number of complaints received and resolved;
	  - Number of grievances received and resolved;
	  - Services furnished to participants.
	
	The MCO is required to submit a quality report on an annual basis including standard measures, method of review, recommendations for improvement, and evaluation of corrective actions implemented.

Element	Description
6. LTSS-Focused PIPs	The ACAP MCO is required to conduct 1 PIP. ACAP is part of a larger effort with the state Medicaid Agency to utilize an EQRO. The state has worked directly with the MCO and the EQRO to develop a PIP that is relevant to the ACAP population. In addition, if deficiencies are identified by the MCO or the state, the MCO is required to develop a corrective action plan to improve performance.
7. Care Coordination	The state conducts the initial eligibility assessment and forwards the information to the MCO. The state also asks families to complete a questionnaire regarding the applicant's contact with law enforcement, psychiatric hospitalization, and crisis intervention within past year. The MCO is expected to meet with applicant to develop an initial support plan within 14 days of being notified by the state that an applicant is eligible for enrollment. The MCO also conducts a psychosocial assessment, a Scale of Independent Behavior Revised, and quality of life survey. The MCO also requests that participants who live with or very involved with family complete a parental stress scale. The results of all of the information is transmitted to the state's information system. The participant's plan must be reviewed at least every 3 months, and after each episode that triggers implementation of the crisis intervention plan or the use of a restraint. Monitoring and annual reassessments must address the participant's progress toward more inclusive and less restrictive services than were provided the previous year. The MCO is required to complete an assessment annually designated by the state for each participant transmits the results of the assessments to the state in an electronic format. The MCO is required to assign a team to each participant responsible for assessment, service planning, delivery of services, quality of services, and continuity of care. The team includes at a minimum: • Participant/guardian/family (consistent with the participant's or guardian's wishes); • Behavioral Health Specialist; • Supports Coordinator. The MCO is required to ensure that every participant has an assigned PCP. The PCP may be a specialist, if the needs of a participant warrant. The MCO is required to ensure that the authorized services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO must establish practice guidelines to govern the authorization and delivery of services, which are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, consider the needs of the participants, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate. Practice guidelines must be approved by the state before being implemented. Guidelines must be shared with all affected providers and, upon request, with participants and applicants.

Element	Description
	The MCO must use a person-centered planning process in developing the Initial ISP and in developing, reviewing, and updating or revising the FBA-based ISP. The process must include: • Understanding the participant's present and future needs and desires. • Identifying the services and other supports the participant will need to meet his or her needs and desires. • Determining what steps need to be taken to meet the participant's needs and desires. The MCO s required to develop a crisis intervention plan to plan for a crisis event to protect the partitioned from hurting himself/herself or others. The MCO will reassess the plan to avoid a crisis event in the future. A description of how the effectiveness of the plan and its implementation in supporting the participant will be monitored and evaluated on a regular basis and after each crisis event.
8. 24-Hour Back-Up	The MCO is required to maintain an after-hours call-in system to provide access, 24 hours per day, 7 days per week for covered services when medically necessary.
9. CI Reporting and Investigation	The MCO must ensure each provider responds, reports, and follows up on CIs as specified by the state. The state has a list of incidents that the MCO must use in their process. The MCO must use the state web-based program --called EIM. All incidents must be reported in the EIM within 24 hours of occurrence or awareness of incident. The MCO has to report preliminary information/demographics, information on what was done to ensure health and welfare during and after incident, and an incident description narrative. The state gets an alert that an incident was reported and reviews this information within 24 hours. The MCO has 30 days from completion of the initial section to then complete the report. The state reviews the completed report and then either closes the report or the state will ask for clarification on actions taken/information reported. The MCO is expected to trend and analyze incident reports. The state monitors the MCOs performance as part of the annual review where participant records are reviewed (for example, did all incidents get reported?). The MCO is required to develop Seclusion and Restraint policies and procedures and ensure that staff and providers receive training on these policies and the appropriate use of these restraints identified in the approved behavioral support plan. MCOs are required to file an incident report any time a Restraint is used.
10. Mortality Review	The MCO is expected to review every death. The MCO is required to report all deaths to the state via the CI reporting systems described above. The MCO is also expected to review each death and reports the results of this review to the state.

Element	Description
11. EQRO Responsibilities	ACAP is part of a larger effort with the state Medicaid Agency to utilize and EQRO. The EQRO reviews the MCO's activities and generates a compliance report and evaluation of the MCOs PIP. The MCO is required to comply with requests from the state for submission of data required to complete an annual external independent review of the quality outcomes, timeline and access to authorized services. The MCO is also required to cooperate with the state/authorized representatives in the state's monitoring of MCO and provider compliance with the contract requirements and the provider's performance as it relates to participant outcomes and consistency of quality indicators.
12. Ombudsman/ Function	The MCO has a complaint, grievance and state fair hearings procedures that is approved by the state. The MCO informs each participant verbally and via the Participant Handbook of the participant's right to file a complaint or grievance, the requirements and timeframes for filing a complaint or grievance, the availability of assistance in the filing process, the toll-free numbers that the participant can use to file a complaint or grievance, and the participant's right to request the state's Fair Hearing. The MCO must also inform the provider of the right of each participant to file a complaint or grievance. The MCO also has established a committee with representation from participants, family members, and MCO staff to discuss program issues. In addition, the state encourages and receives direct inquiries from participants and family members and works directly with participants and the MCO to resolve any issues. The state does not have independent ombudsman available to participants in ACAP.
13. Experience of Care/ Satisfaction Surveys	The MCO is required to regularly evaluate participants' satisfaction with services using their satisfaction survey. Performance measures related to the survey focus on: • Increase in percentages of participants with jobs or volunteer opportunities. • Participant satisfactions and quality of life indicators. The state is working with a consortium of autism experts to enhance this process. Also, the MCO holds monthly meetings in various counties with family members and participants to gather feedback from participants. The state ACAP Monitors also meet with families and participants (approximately 15% of the ACAP participants) and complete satisfaction questionnaires during their annual review process. A findings report is sent to the MCO with a request for plans of correction if indicated. The state also discusses the results of their reviews during the monthly meetings held with the MCO. The state plays and active role (via monthly meetings) in supporting the MCO to address gaps/issues identified. This is especially important when focusing on the challenges of supporting adults with autism.

Element	Description
14. Membership Oversight	The MCO includes participants on their Quality Committee and Advisory Committee. The MCO host meetings with families of participants at least every other month to discuss the services and supports offered by the ACAP. The state also hosts focus group meetings with participants to gather feedback and modify policies and procedures as needed. A participant also sits on the state's Advisory Board and the 3 regional advisory boards established by the state. Participants are also invited to attend the state's annual Autism Training Conference where participants can share their experiences with the state, MCO and providers.
15. State Technical Assistance to MCOs	The state maintains a close relationship with MCO. The state supports the MCO in all aspects of their QM systems including the use of state's information system for reporting incidents and documenting support plans.
16. MCO Report Cards on LTSS	None specified.
17. Financial Incentives, Penalties and Withholds	The state does not have financial incentives related to quality. The state does have the ability to withhold payment based on poor performance (for example, the MCO does not make required corrections or does not meet identified standards) but they have not needed to do this to date.
18. Other Quality Management/ Improvement Activities	None specified.

ACAP = Pennsylvania Adult Community Autism Program
CI = critical incident
EIM = Enterprise Incident Management
EQRO = external quality review organization
ER = emergency room

ISP = Individualized Service Plan
IT = information technology
LTSS = long-term services and supports
MCO = managed care organization
MH = mental health

MLTSS = managed long-term services and supports
PCP = primary care provider
PIP = performance improvement project
QM = quality management
SP = service plan

APPENDIX F. TENNESSEE'S CHOICES IN LONG-TERM CARE

Element	Description
MLTSS Program	CHOICES in Long-Term Services and Supports
Lead Agency	Bureau of TennCare
Medicaid Authority	1115 Demonstration Waiver
Inception	TennCare initiated in 1994.
Year LTSS Added	2010
Groups Enrolled	Persons of all ages residing in nursing homes. Adults 21+ with a PD/LTSS needs. Seniors 65+ with LTSS needs.
# Enrolled	31,890 (as of September 1, 2013 in CHOICES. 1.2 million enrolled in the broader TennCare managed care program.
1. State Quality Oversight Infrastructure	For quality oversight, CHOICES relies on both **TennCare's Quality Oversight Division** (which also monitors the acute and behavioral health components of TennCare), as well as on 2 units in the Division of LTSS (the **Audit and Compliance** unit and the **Quality and Administration** unit). **TennCare's Quality Oversight Division** assumes responsibility for oversight of each MCO's Care Coordination activities through comprehensive reviews of member records from receipt of referral to implementation of services. This review includes determining if all timelines for contacts were met as well as assessing whether the member was involved in the service planning process, whether the POC accurately addressed needs and risks, and whether the POC was appropriate based on information in the required CNA and risk assessment/risk agreement. **LTSS Division's Audit and Compliance Unit** processes routine reports from the MCOs and conducts contract compliance audits. This unit receives reports from the MCOs and conducts on-site LTSS audits of MCOs, assembles the reports and audits into aggregate regional and statewide data sets, analyzes the data and produces actionable information for other LTSS units. **LTSS Division's Quality and Administration Unit** works in collaboration with the TennCare Contract Compliance and Performance Division and the Quality Oversight Division to monitor LTSS contract compliance and the quality of LTSS provided. In that role, this unit provides technical assistance, training and support to the MCOs and is typically in daily contact with the MCOs regarding operation of the LTSS program. This division is responsible for leading quarterly joint meetings with the MCOs to discuss quality concerns and opportunities for improvement. The unit fields member inquiries and is responsible for monitoring changes needed in the MCO contracts, or policies/protocols and rules related to LTSS. This unit is also responsible for the oversight of the MCOs' management of the EVV which tracks members' timely receipt of LTSS in real-time. This unit also monitors referrals between the single point of entry (AAAD) and the MCOs. It also monitors MCO customer service and provider service telephone lines as well as AAAD intake and referral lines.

Element	Description
2. State IT Infrastructure for Supporting Quality Oversight	TennCare utilizes a commercially available web-based tracking tool that has been customized by TennCare's Project Management unit for tracking contract compliance. Management of this tracking system is led by the OCCP. MCOs submit all required reports, member materials and corrective action plans, as well as associated communications through the OCCP tracking tool. All submissions by the MCO requires an action in the automated report/communication by a TennCare business owner who must accept or reject the report/corrective action plan and indicate the reason for the action. This tool documents all communications between TennCare and each MCO, and actions regarding any MCO deliverable.
3. MCO Quality Oversight Responsibilities	MCOs are required to have a QM/QI program that is accountable to the MCO's board of directors and executive management team, have a QM/QI committee that oversees the QM/QI functions and a staff person responsible for all QM/QI activities. The QM/QI committees are required to include medical, behavioral health, and LTSS staff and contract providers (including medical, behavioral health, and LTSS providers). The QM/QI committee is required to notify the CMO of TennCare of meetings in a timely fashion and to the extent allowed by law, the CMO of TennCare, or his/her designee, may attend the QM/QI committee meetings at his/her option. MCOs are required to monitor providers' performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations. A staff person must be responsible for all UM activities, including overseeing prior authorizations. MCOs must have a senior executive responsible for overseeing all subcontractor activities. MCOs are responsible for confirming the provider's capacity and commitment to initiate LTSS, and for monitoring the provider's delivery of services to ensure members' timely receipt of LTSS specified in the POC. MCOs are required to review all reports submitted to the state to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement QI activities to improve performance and ensure future compliance.

4. State Audits of MLTSS Program	The LTSS Audit and Compliance Unit currently conducts 7 types of audits:
	• **New Member Audit (quarterly)**. This audit is usually conducted at the same time as the Referral Audit. For members who are new to Medicaid and CHOICES ("new" members), it addresses:
	  - Whether CNA and person-centered POC were completed timely.
	  - Whether MCO authorized all HCBS identified in member's POC.
	  - Whether HCBS delivered timely.
	• **Referral Audits (quarterly)**. This audit is usually conducted in conjunction with the New Member Audit. For existing Medicaid enrollees who are referred for CHOICES (referrals), this audit addresses:
	  - Whether MCO conducted telephonic screening.
	  - Whether MCO conducted face-to-face visit to complete LOC eligibility application (PAE).
	  - Whether PAE submitted to TennCare timely.
	  - Whether CNA and person-centered POC were completely timely.
	  - Whether MCO authorized all HCBS identified in member's POC.
	  - Whether HCBS were delivered timely.

Element	Description

	• **CI Audit (semi-annually)**. This audit addresses:
	  - Whether the MCO accurately identified and categorized CIs, received CI reports within maximum timeframe (from its staff, HCBS providers and/or FEA), and reported CIs timely to TennCare.
	  - Whether the MCO ensured appropriate and timely care of CHOICES members after the occurrence of CIs, gathered evidence regarding CIs and obtained investigative reports and/or corrective action information timely from HCBS providers and/or the FEA.
	  - Whether the MCO ensured that appropriate investigations were conducted and corrective actions plan were implemented by staff, contract HCBS providers and FEA within established timeframes.
	• **FEA Audit (annually)**. This audit addresses:
	  - Whether the FEA assigned the member a supports broker and notified the care coordinator within 2 business days of MCO referral date.
	  - Whether the contractor notified the member of their assigned supports broker, along with contact information, within 5 business days of the MCO referral date.
	  - Whether services began within 60 days of MCO referral date. If services did not begin timely, was there documentation showing why.
	  - Whether the contractor conducted at least semi-annual face-to-face visits in the member's residence after the CD starts date and if each member had a back-up plan.
	  - Whether the contractor ensured all specified member and worker requirements were complete before service initiation.
	• **AAAD Audit (annually)**. This audit addresses:
	  - Whether the agency documented and responded to I&R requests within the specified timeframe; and appropriately categorized and documented inquiries in which the potential member was unable to be contacted.
	  - Whether the agency demonstrated attempts to contact such members or potential members in accordance with the grant contract.
	  - Whether the agency contacted individuals referred through the MDS process within the specified timeframe; conducted a face-to-face screening with eligible MDS referrals within the specified timeframe; demonstrated confirmation of receipt of referrals faxed to MCOs, and maintained referral intake records.
	  - Whether the agency ensured face-to-face assessment occurred within prescribed guidelines of initial screening, or in the absence of a screening, within specified timeframe of CHOICES referral; facilitated the applicant's Medicaid application; completed the PAE; submitted the completed PAE to the Bureau with all information necessary for a LOC determination; if applicable, and provided documentation of members' decision to terminate the enrollment process.
	• **MFP Audit (annually)**. This audit addresses:
	  - Whether the contractor verified the member's eligibility to participate in the MFP program, including properly qualifying the residence.
	  - Whether the contractor provided a written notice to member of MFP enrollment and/or disenrollment. Whether contractor recorded MFP enrollment and/or disenrollment in member's POC.
	  - Whether the contractor reported inpatient admissions and discharges to TennCare properly and timely.
	  - Whether the contractor conducted face-to-face visit(s) with member after transition and following an inpatient admission according to prescribed guidelines.

Element	Description
	• **Provider Qualifications Audit (annually)**. This audit addresses the MCO processes for examining provider qualifications before including them in the network: - Observation of provider licensure and notification of acceptance into the provider network. - Whether the contracted provider is actively licensed by the appropriate licensing organization. TennCare's Quality Oversight Division conducts audits semi-annually on each MCO to evaluate care coordination contractual responsibilities, including: • Whether members who meet NF LOC are offered freedom of choice between HCBS and NF services (semi-annual review). • Whether POC is reviewed/updated at least annually (annual review). • Whether education of member/family occurred on how to identify and report Abuse, Neglect and Exploitation (reviewed annually). • Whether member was informed of their right to a fair hearing (semi-annual review) upon initiation of any adverse action. • Whether CIs are reported within specified timeframes (semi-annual review). • Whether members meet LTSS LOC criteria (reviewed quarterly). If deficiencies are discovered, a Plan of Correction is required. The Oversight Division has multiple approaches to monitoring the delivery of care coordination by the MCOs, including: • Visits with the care coordinator--also called "*ride-alongs*" where state staff accompany the care coordinator on member visits and assess the care coordinator's ability to meet all contractual care coordination requirements. Quality Oversight conducts 6 visits per quarter per MCO. The visits are typically "ride-alongs" with care coordinators to both HCBS and NF members. Members who are visited may be chosen randomly or by care coordinator or geographic area (county). Following the *ride-alongs* Quality Oversight staff holds a debriefing with MCO CHOICES management staff to identify strengths and opportunities for improvement. • POC Review. The state also conducts a review of care plans from all care coordinator visits as well as a random sample of 30 per MCO per quarter. The care plans are reviewed to insure they meet all contractual requirements. An inter-rater reliability study is also conducted. If any problems are detected, the MCO is required to remediate all deficiencies. • In order to assess ongoing care coordination, each year the state follows 1 enrollee per MCO to assure that all care coordination processes are completed and service coordination is timely. (This is in addition to LTSS Audit and Compliance Audits which review a much larger sample of members.) • The state conducts quarterly visits with each MCO to review any issues identified in monitoring of care coordination contractual requirements.

Element	Description
	The state also conducts <u>Provider Network Adequacy Monitoring</u>. It uses a GeoAccess software application to identify potential deficiencies in each MCO's provider network. Reports are prepared for each MCO on a monthly basis using this software. Reports help identify trends regionally and by provider type/specialty. The software calculates distance/driving times between providers and members. There are different standards for different services. The standards for Adult Day Care specify that members from urban areas must not have to travel more than 20 miles to adult day care services; for members living in suburban locations, not more than 30 miles, and those from rural areas not more than 60 miles. For other LTSS HCBS the MCO must contract with at least 2 providers per service type (e.g., assistive technology; attendant care, home-delivered meals, etc.) in each county of the state's 3 regions to ensure freedom of choice. Timely access to services is also monitored through ongoing review of member appeals for CHOICES LTSS.
5. Performance Measures and Quality-Related Reports	The state develops quality-related performance measures responsive to some assurances/sub assurances associated with the Medicaid 1915(c) program--related to LOC, service planning, provider qualifications, and health and welfare (education of member/representative regarding identification about abuse, neglect, exploitation; and timely reporting of CIs). MCOs must submit the following LTSS quality reports: • Late/Missed Visit Reports (by MCO by HCBS type, including reason for missed/late visit). • Quarterly reports from AAADs (single point of entry) on timeliness of I&R requests, CHOICES screenings/assessments. • Nursing Facility-To-Community Transitions Report by MCO including community tenure. • Consumer Direction Reports including timeliness from FEA referral to receipt of consumer-directed services. • CIs Reports (quarterly) by residential setting and provider type (agency vs. consumer direction). • Quarterly Complaints Report including resolution. • CHOICES Advisory Group Report--(required to meet quarterly; reports are submitted semi-annually), including meeting dates and topics the group addressed. • Annual Qualified Workforce Strategies Report by MCO. • Care Coordination Reports, including timeliness of face-to-face and telephonic contacts as well as timely completion of the annual reassessment. • Monthly Caseload and Staffing Ratio Report. • Quarterly MFP Participants Report. • Quarterly Cost-Effective Alternative Report. • Quarterly Behavioral Health Adverse Occurrences Report details the number of adverse occurrences, date of occurrence, type of adverse occurrence, location, provider name; and action taken by facility/provider.

Element	Description
6. LTSS-Focused PIPs	MCOs (with assistance from the EQRO) are required to conduct PIPs--2 clinical and 3 non-clinical. The 2 clinical PIPS must include 1 in the area of behavioral health that is relevant to 1 of the Population Health (DM) programs and 1 in the area of either child health or prenatal health. Two of the 3 non-clinical PIPs must be in the area of long-term care. In 2012, all MCOs were required to conduct a PIP on LTSS rebalancing, and were allowed to choose the topic of the other PIP. Other LTSS PIPs conducted included 1 on utilization of Adult Day Care by CHOICES members; 1 on the culture of integration between physical and behavioral health for CHOICES members; and a third on depression screenings for a CHOICES members receiving HCBS and who are NF-eligible.
7. Care Coordination	Comprehensive Care Coordination is provided by the MCOs. Each CHOICES member has an assigned Care Coordinator (nurses and social workers). Care coordinators are responsible for coordination of the physical, behavioral, functional and social support needs of the member as well as management of chronic conditions and care transitions. Care coordinators are responsible for completing the PAE form utilized by the state to make LOC determinations. Care coordinators are also responsible for completion of the CNA, the risk assessment and risk agreement, and developing the POC and updating the POC as needed. MCOs develop and utilize their own CNA instruments and care planning formats which must include minimum elements specified by TennCare and be approved by TennCare. Members have a right to request an objective review by the state of their needs assessment and/or care planning process. Care coordinators conduct a risk assessment using a state-approved tool, following protocol developed by the state, and develop a state-specified risk agreement to be signed by the applicant or his/her representative which will include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk. MCO care coordinators review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign and date any revised risk agreement.

Element	Description
	MCOs have DM (recently changed to "Population Health") contractual requirements that specify that the MCO must have methods for integrating CHOICES care coordination into its DM program and methods within its DM and Care Coordination programs for supporting the continuity and coordination of covered physical and behavioral health, and LTSS benefits as well as coordination with the providers of such services. Predictive modeling methods are used to identify TennCare individuals for a given DM program. If a CHOICES member is identified in a DM program, DM staff must contact the CHOICES care coordinator to ensure the required continuity and coordination of applicable benefits. DM staff will also take referrals from CHOICES care coordinators. Care coordinators, not DM staff, are the conduit to the member. Care coordinators are responsible for reviewing educational materials with the member and caregiver, and for integrating aspects of DM that would help to better manage the member's condition into the POC. The care coordinator is also the conduit to the member's physician regarding DM. Care coordination ratios are recommended but not mandated by the state. However, the MCO is required to submit a monthly caseload and staffing ratio report. If the state finds the MCO out-of-compliance on any care coordinator contractual requirements and the MCO has care coordination ratios that are in excess of the state's recommended ratios, the state will double the amount of liquidated damages that may be assessed against the MCO.
8. 24-Hour Back-Up	A written back-up plan is required as a component of the POC for all members receiving companion care or non-residential HCBS. The plan must identify individuals and/or providers who are willing to be available as needed when a regularly scheduled worker or provider is not able to provide services. The care coordinator must ensure the adequacy of the back-up plan. Using the EVV system, MCO's are required to monitor member receipt and utilization of scheduled personal care visits, attendant care, in-home respite, companion care, home-delivered meals, and adult day services. The EVV system is programmed with the day and time a service provider is expected based on the member's needs and preference (member-preferred scheduling). MCOs and contracted providers receive real-time alerts when a worker does not log in at the designated time. This allows the MCOs to resolve any potential gaps in service immediately. When a member's back-up plan must be implemented, the care coordinator is responsible for ensuring the plan was implemented and appropriate back-up workers or services are in place. Both the MCO and the state use reports from the EVV system to identify and track areas for QI (late/missed visits).

Element	Description
9. CI Reporting and Investigation	The state requires that MCOs have plans and protocols in place for the prevention, reporting and investigation of CIs. • MCOs must develop and implement an abuse/neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of members; a plan for educating and training providers, subcontractors, care coordinators, and other MCO staff regarding these protocols; and a plan for training members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect. • MCOs are required to develop and implement a CI reporting and management system for incidents that occur in a HCBS delivery settings. CIs include: suspected physical, sexual, mental or emotional abuse, neglect, unexpected death, theft, financial exploitation, medication error, severe injury, other (e.g., falls, damage to member's property). CIs must be reported to the MCO within 24 hours, and investigated within 30 days. • MCOs are required to identify and track CIs and must review and analyze CIs to identify and address potential and actual quality of care and/or health and safety issues. The MCO must regularly review the number and types of incidents and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS. • MCOs must require its staff and contract CHOICES HCBS providers to report, respond to, and document CIs as specified by the contractor. MCOs must report to TennCare any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within 24 hours of detection or notification. In addition, the state requires MCOs to submit quarterly reports on the number and type of CIs experienced by its HCBS member population. If an incident is reported to APS, the MCO is required to submit a copy of that CI report to the state. In addition, the state conducts semi-annual audits of the MCOs handling of CI reports and investigations (see #4 State Audits).
10. Mortality Review	A member's death must be reported to TennCare within 24 hours of notification to the MCO. Any unexpected death of a member that is receiving HCBS must be reported as a CI. The MCO is required to conduct the appropriate investigation or report the death to Adult Protective Services if the unexpected death is suspected to be a result of abuse or neglect of the member.
11. EQRO Responsibilities	In addition to the federally-required Annual Quality Survey of each MCO, the performance measure validation, and the PIP validation, TennCare requires the EQRO to assist MCO's with PIPs, HEDIS/CAHPS reports, and training MCO and TennCare quality staff. If any deficiencies are uncovered in the compliance review, the EQRO reviews (with the state Quality Oversight staff) all corrective action plans; if the state deems the corrective action plans unacceptable, the states' Quality Oversight division works with the EQRO to develop an acceptable plan. The EQRO also is responsible for a legislatively-mandated annual network adequacy review and for training MCO and TennCare quality staff.

Element	Description
12. Ombudsman/ Function	The state has a Long-Term Care Ombudsman Program, a statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the state. The Ombudsman is available to assist CHOICES member and their families (as well as private pay and Medicare nursing home residents) resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the TCAD. TennCare also requires MCOs to employ a consumer advocate responsible for internal representation of members' interests including input into planning and delivery of long-term care services, QM/QI activities, program monitoring and evaluation, as well as member, family, and provider education. The state is currently exploring options for expanding the Long-Term Care Ombudsman Program to include all (and not just residential) HCBS.
13. Experience of Care/ Satisfaction Surveys	The state contracts with the AAADs to conduct an annual CHOICES member survey; items for the survey are derived from the PES and the MFP Quality of Life Survey. The survey's primary focus is on the member's experience of care. Upon completion of the surveys, the AAADs submit the responses to the EQRO who is contracted to analyze the data and compile the survey result report. In addition, TennCare requires the FEA to conduct an annual consumer satisfaction survey specific to the participant's experience in consumer direction. All (100%) consumer-directed members are asked to participate in the survey.
14. Membership Oversight	Stakeholder meetings are organized by the state, at minimum, semi-annually. Annual reports are provided to all stakeholders. In addition, each MCO is required to have a CHOICES Advisory Group that must meet quarterly. The advisory group provides input into the development of the MCO's policies and procedures, planning and delivery of LTSS, quality activities, program monitoring/evaluation and member/family/provider education. 51% of the group must be comprised of member and/or their representatives. Membership also includes representatives from the provider and advocacy communities.
15. State Technical Assistance to MCOs	The state's LTSS Quality and Administration Unit, through required reporting elements, member experience, and provider and stakeholder feedback, identifies areas of needed process, operations or service delivery system improvement. Likewise, the OCCP and Quality Oversight Divisions may identify improvement opportunities. TennCare provides technical assistance through scheduled and routine interactions with each MCO.
16. MCO Report Cards on LTSS	Using ongoing analysis of data from required reports and on-site audit processes, the LTSS Audit and Compliance Unit is developing an MCO report card for LTSS. Currently the report (which continues to be refined) is utilized primarily by internal LTSS management staff to help monitor LTSS health plan performance. Over time, specified measures will be integrated with the existing MCO report card for TennCare.

Element	Description
17. Financial Incentives, Penalties and Withholds	The CRA contains provisions for the state to levy financial penalties (i.e., liquidated damages) for failure to meet specified performance standards and benchmarks. Liquidated damages correspond to 3 levels of transgressions/omissions, ranging from those actions/inactions that result in significant threat to the member's care to those that represent threats to the smooth and efficient operation of TennCare. These liquidated damages cover all TennCare services, not just LTSS. The damages range from $250 per day for failure to meet a deliverable timeline to $100,000 per month for failure to meet a threshold for specified care coordination activities, depending on the severity of the issue. Damages assessed for failure to meet specified care coordination requirements can be multiplied by a factor of 2 if the MCO's LTSS care coordination caseload or staffing recommendations are not followed. In addition, TennCare withholds a percentage of each month's capitation payments that is released to the MCO the following month, so long as there are no serious quality or compliance concerns. If there are serious quality or compliance concerns, the withhold is retained by TennCare until the issue is resolved, and if retained for 6 months, is permanently retained by the state. Any quality or compliance concern resulting in the retention of a withhold triggers a higher monthly withhold amount, which is reduced gradually over time, so long as quality and compliance are maintained. Through the MFP Rebalancing Demonstration Grant, TennCare offers a financial incentive for MCOs. MCOs receive $1,000 for every member they transition to the community from a nursing home who also enrolls in the MFP program, up to the MCO's assigned target and $2,000 per transition that exceeds the MCO's assigned target. If the member stays in the community for 1 year and remains enrolled in the MFP program, the MCO receives added financial incentives. There are additional statewide benchmarks the MCOs must accomplish together to receive additional incentive payments.
18. Other Quality Management/ Improvement Activities	None specified.

AAAD = Area Agency on Aging and Disability
CAHPS = Consumer Assessment Health Care Providers and Systems
CI = critical incident
CMO = Chief Medical Officer
CNA = Comprehensive Needs Assessment

CRA = Contractor Risk Agreement
DM = disease management
EQRO = external quality review organization
EVV = electronic visit verification
FEA = Fiscal Employer Agent

HCBS = home and community-based services
HEDIS = Health Effectiveness Data and Information Set
I&R = information and referral
IT = information technology
LOC = level of care

LTSS = long-term services and supports
MCO = managed care organization
MDS = minimum data set
MFP = Money-Follows-the-Person
MLTSS = managed long-term services and supports

NCQA = National Committee on Quality Assurance
NF = nursing facility
OCCP = Tennessee Office of Contract Compliance and Performance
PAE = Pre-Admission Evaluation
PD = physical disability

PES = Participant Experience Survey
PIP = performance improvement project
POC = plan of care
QI = quality improvement
QM = quality management

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

APPENDIX G. TEXAS'S STAR+PLUS PROGRAM

Element	Description
MLTSS Program	Texas STAR+PLUS Program
Lead Agency	Texas Health and Human Services Commission (HHSC)
Medicaid Authority	1115 Research and Demonstration Waiver
Inception	1998
Year LTSS Added	Since Inception.
Groups Enrolled	Medicaid beneficiaries who receive SSI and/or qualify for certain waiver services. Includes dual eligibles.
# Enrolled	400,790 (June 2012) Subset using LTSS is 71,239.
1. State Quality Oversight Infrastructure	Texas HHSC employs 5 FTEs who oversee STAR+PLUS program quality and 3 FTEs who oversee quality for the 5 health plans that serve STAR+PLUS members. In addition, Texas HHSC reports there are 13 area HHSC Medicaid/CHIP Regional Advisory Committees who meet quarterly to discuss and provide recommendations related to Medicaid and CHIP including quality strategy issues. Membership may include representation from the following: • Medicaid/CHIP PCPs; • Specialty providers (including pediatricians); • Rural health providers; • Long-term care providers; • Hospitals; • Consumer advocates; • Members who use or have used Medicaid/CHIP services; • Medicaid/CHIP MCOs; • Political subdivisions with a constitutional or statutory obligation to provide health care to indigent patients; • School districts; • Faith-based organizations. These groups review program data and policies and make recommendations. Recommendations from this group are shared with health plan management staff as a QI process. There is also a STAR+PLUS workgroup that meets on a quarterly basis as well as a state level quality committee that inform the QI process.

Element	Description
2. State IT Infrastructure for Supporting Quality Oversight	In Texas, the state and MCOs have benefitted from using encounter data to track quality. The state reports they have been able to use encounter data effectively by having consistent staff that have been working in the encounter data system for a long while. Over time, they have increased the number of edits and encounter data is cleaner. The state, in collaboration with the EQRO has and the University of Florida School of Engineering developed the ThLC. ThLC is a web portal that allows the MCOs and HHSC staff to view quality of care results by program (e.g., STAR, STAR+PLUS), health plan, service area, gender, race/ethnicity, and other key variables. The portal is interactive and allows MCOs to interact and share documents. The portal also contains results for HEDIS measures and PPE measures for admissions, readmissions, and emergency department visits. The portal currently contains Medicaid data but there are plans to populate it with Medicare data in the future. The portal allows MCOs to conduct trending as it currently contains 3 years worth of data. There are future plans to provide this portal at the provider level. ThLC has a great deal of flexibility in reporting. It can focus on specific geographic areas; however, it cannot report on areas with fewer than 20 individuals. The portal can also sort by provider and has some registry information. The portal can post the registry information on an HHSC location and the health plan can access it. MCOs can see doctor and patient information and use it to follow up on specific issues such as flu shots. The STAR+PLUS MCOs are regularly using the registries. The state also works with the EQRO to maintain a data repository with linked health care claims and encounter data, enrollment files, HEDIS, PPE, and CAHPS survey results. As the EQRO's responsibilities have evolved so has the information provided. HHSC provides the necessary information to them, in the form of data extracts, that provides the state with the basis for calculating HEDIS measures, CDPS risk scores, certified data sets for Managed Care capitation rate-setting, Potentially Preventable Readmissions, Potentially Preventable Complications, Encounter Data Quality Logs and other ad hoc information. Texas is currently planning for a new data enterprise system with the hopes that this system will be able to provide line managers and program coordinators with the ability to pull and manage data for QI efforts.

Element	Description
3. MCO Quality Oversight Responsibilities	MCOs must conduct PCP and other provider profiling activities at least annually. Provider profiling activities must include, but not be limited to: • Developing PCP and provider-specific reports that include a multi-dimensional assessment of a PCP or provider's performance using clinical, administrative, and member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population. • Establishing PCP, provider, group, service area or regional benchmarks. • Providing feedback to individual PCPs and providers regarding the results of their performance and the overall performance of the provider Network. MCOs are also required to ensure network adequacy by verifying that covered services furnished by providers are available and accessible to members in compliance with established appointment wait time standards and within established geographical standard for covered services furnished by PCPs. The MCO must enforce access and other network standards required by the contract and take appropriate action with providers whose performance is determined by the MCO to be out-of-compliance.
4. State Audits of MLTSS Program	A process used to evaluate MCOs is the AIT. This is an administrative questionnaire, developed and administered by the EQRO that is sent to the MCOs on an annual basis that covers policies, procedures and other administrative items related to QA. Based on MCO responses and other items such as MCO tenure or performance, the EQRO will follow-up with conference calls or site visits if needed.
5. Performance Measures and Quality-Related Reports	Texas HHSC works with the EQRO to collect all applicable HEDIS measures on the STAR+PLUS program population. In addition ICHP calculates the CDPS risk scores, and PPEs for STAR+PLUS members. Additional measures specific to LTSS include the following: • Percent STAR+PLUS members with good access to Service Coordination not collected not collected. • Percent increases in STAR+PLUS members that receive personal attendant and/or respite services through the consumer-directed services delivery model. • Number of STAR+PLUS members entering NF. • Number of STAR+PLUS 1915(c) waiver clients returning to community services. Texas HHSC noted that they are currently facing challenges as they perceive there are not a lot of good standardized LTSS measures. They are considering developing their own LTSS measures with ICHP.

Element	Description
6. LTSS-Focused PIPs	The EQRO provides technical assistance and works with the MCOs in developing PIPs based on identified areas where improvement is needed and based on the state's overarching goals for the STAR+PLUS Program. The EQRO submits a summary report to HHSC on each MCO's PIP in terms of appropriateness, adequacy of design and other factors necessary to conduct a strong PIP. The EQRO reports that Texas has just started collaborative PIPS this year. The EQRO also reports that there have also been PIPs in the past around reducing nursing home admission rates. They identified that the SP was important. Some literature suggests that if you comply with antidepressant medication it can reduce nursing home admissions. One MCO focused on depression screening and found it helpful in reducing nursing home admissions. Another focus for PIPS for STAR+PLUS health plans is diabetes care. They are trying to improve compliance with testing. They would also like to shift the current focus of test compliance and collect actual data (lab results) as a part of PIPs.
7. Care Coordination	Presently, MCOs are required to provide a service coordinator (care coordinator) to all STAR+PLUS members who request one. The MCO must also provide a service coordinator to STAR+PLUS member when the MCO determines one is required through an assessment of the member's health and support needs. The MCO is required to contact each STAR+PLUS member a minimum of 2 times per calendar year. This contact can be written, telephonic, or in-person, depending upon the member's level of need. The MCO must document the mechanisms, number and method of contacts, and outcomes.
8. 24-Hour Back-Up	There is currently no requirement for a 24-hour back-up system.
9. CI Reporting and Investigation	CI data is provided to the state by the MCO through the complaint system on a quarterly basis. Additionally, HHSC reviews all investigation reports provided by Texas DFPS. Based on the content of the report, HHSC may conduct an on-site survey of the provider or require the provider to submit evidence of follow-up action on the incident. The investigative findings and HHSC's follow-up on those findings is entered into the abuse, neglect, or exploitation database by HHSC staff. HHSC also records deaths in a database. Reports of CIs are compiled on a monthly basis for each program provider. In preparation for annual and some intermittent reviews of providers, HHSC staff compiles data related to all CIs reported by or involving the program provider. HHSC may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure appropriate follow-up was conducted by the provider. All abuse, neglect and exploitation reported to the DFPS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

Element	Description
	Oversight activities occur on an ongoing basis. Information regarding validated instances of abuse, neglect or exploitation is monitored, tracked and trended for purposes of training HHSC staff and to prevent recurrence. Providers are responsible for training their staff about reporting CIs and events.
10. Mortality Review	Per MCO report, mortality cases are handled by the MCO Quality department and are investigated as a quality of care case. The Quality staff logs the case and requests the necessary information to conduct the review working in collaboration with other MCO departments as necessary. The case is presented to and discussed with the Medical Director. The Medical Director reviews the case and may request additional information or may speak with the provider. The findings of the case are presented to the Peer Review Committee for recommendations. The health plan carries out the recommendation of the Peer Review Committee. The Quality department tracks quality of care concerns related to providers to identify any trends. Trends identified are brought to the Peer Review Committee for discussion and recommendation. Data from this process is provided by the MCO to the state on a quarterly basis.
11. EQRO Responsibilities	The EQRO, the ICHP at University of Florida, also plays a large role in evaluating the quality of the program as well as Texas CHIP and other Texas managed care programs. Texas HHSC contracts with the EQRO to conduct an annual independent review and all mandatory EQRO activities: (1) determining MCO compliance with federal Medicaid managed care regulations; (2) Validation of performance measures produced by the MCO; and (3) Validation of PIPs undertaken by the MCO. They also conduct a number of additional tasks such as conducting the annual satisfaction survey, validating encounter data and conducting focused studies. The EQRO also conducts calculates and reports performance data for the MCOs in dashboards and MCO report cards. ICHP has assisted Texas HHSC in developing several tools to assist in evaluating the quality of the STAR+PLUS program. ICHP has created a dashboard that management can use to view the performance of the STAR+PLUS MCOs. ICHP is also working with Texas HHSC to finalize a legislatively-mandated MCO report card. There are plans to publish this report card on the state website for public reporting purposes. In developing the format for this MCO report card, ICHP worked with University of Florida School of Journalism to conduct focus groups with Medicaid beneficiaries, including STAR+PLUS program participants, to determine what type of public reporting members wanted. Focus group findings reveal that beneficiaries wanted pictures, big print and diversity among the people featured in the pictures. Texas used this information in designing their MCO report cards. Texas HHSC staff noted that in working on the report card for STAR+PLUS difficulty was encountered in comparing members who are dually eligible for Medicaid and Medicare and those who are eligible for Medicaid only. They noted a need to take great pains to ensure that the encounter data is correct.

Element	Description
	Another tool that is used to evaluate MCOs is the AIT. This is an administrative questionnaire, developed and administered by the EQRO that is sent to the MCOs on an annual basis that covers policies, procedures and other administrative items related to QA. Based on MCO responses and other items such as MCO tenure or performance, the EQRO will follow-up with conference calls or site visits if needed. Texas HHSC has also worked with worked with their EQRO to track quality for over 10 years. In addition to conducting the activities required by CMS including validating PIPs, validating performance measures and conducting MCO reviews, the EQRO also validates encounter data and calculates performance measures for Texas HHSC.
12. Ombudsman/ Function	Texas HHSC has an Office of the Ombudsman which operates "The Medicaid Managed Care Helpline." This helpline is designed to help Medicaid beneficiaries who need help accessing health care services. The office places a priority on individuals with urgent or complex health care needs. Help offered through the helpline includes: • Information about the client's coverage. • Guidance on how to access services. • Referrals to the right place to get help. • Direct assistance from staff to resolve a problem. The Medicaid Managed Care Helpline also provides general information about managed care programs to providers, health plans, community-based organizations and other stakeholders. The ombudsman's function is to work together with Medicaid/CHIP Health Plan Management and the MCO to resolve the member's or provider's issue. There is also a long-term care ombudsman at the state's Department of Aging and Disability Services. Texas HHSC staff report that the 2 ombudsman programs work closely together. Additionally, the MCO is required by contract to provide Member Advocates to assist members. Member Advocates must be physically located within the service area and must inform members of their rights and responsibilities, the complaints and appeals process and the array of services that are available to them. Member Advocates must also assist members in writing complaints and are responsible for monitoring the complaint. Member Advocates are responsible for making recommendations to MCO management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for helping or referring members to community resources available to meet member needs that are not available from the MCO as covered services.
13. Experience of Care/ Satisfaction Surveys	The EQRO conducts the CAHPS Experience of Care Survey with STAR+PLUS program participants on an annual basis. The standard CAHPS questions are supplemented with some LTSS-focused questions about unmet service needs, and ADLs, etc. MCOs also conduct their own consumer satisfaction survey. The MCO that was interviewed reported that it has attempted to develop some LTSS-specific survey questions to supplement their consumer satisfaction survey; however, it has proved difficult to analyze results without having specific information on the LTSS services the program participants were receiving.

Element	Description
14. Membership Oversight	Texas HHSC reports there are 13 area HHSC Medicaid/CHIP Regional Advisory Committees who meet quarterly to discuss and provide recommendations related to Medicaid and CHIP including quality strategy issues. Membership may include representation from the following: • Medicaid/CHIP PCPs; • Specialty providers (including pediatricians); • Rural health providers; • Long-term care providers; • Hospitals; • Consumer advocates; • Members who use or have used Medicaid/CHIP services; • Medicaid/CHIP MCOs; • Political subdivisions with a constitutional or statutory obligation to provide health care to indigent patients; • School districts; • Faith-based organizations. These groups review program data and policies and make recommendations.
15. State Technical Assistance to MCOs	The AIT, Performance Dashboards, routine reports and routine interactions with the state determine the need for technical assistance.
16. MCO Report Cards on LTSS	The EQRO is working with Texas HHSC to finalize a legislatively-mandated MCO report card. This report card will be published on the state website. In developing the format for this MCO report card, ICHP worked with University of Florida School of Journalism to conduct focus groups with Medicaid beneficiaries, including STAR+PLUS program participants, to determine what type of public reporting members wanted. Focus group findings reveal that beneficiaries wanted pictures, big print and diversity among the people featured in the pictures. Texas used this information in designing their MCO report cards. Texas HHSC staff noted that in working on the report card for STAR+PLUS difficulty was encountered in comparing members who are dually eligible for Medicaid and Medicare and those who are eligible for Medicaid only. They noted a need to take great pains to ensure that the encounter data is correct.
17. Financial Incentives, Penalties and Withholds	The state has established the following quality-related financial incentives: • 5% risk--The state will place each MCO at risk for 5% of the Capitation Payment(s). If the MCO meets the performance expectations they will receive up to 100% of the risk reserve. • Quality Challenge Award--If 1 or more MCOs are unable to earn the full amount of the performance-based at risk portion of the Capitation Rate, the state will reallocate all or part of the funds through the MCOs Program's Quality Challenge Award. The state will use these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. The state will determine the number of MCOs that will receive these funds annually based on the amount of the funds to be reallocated. • Additionally, there are programs based on inpatient and nursing home utilization. These MCOs must achieve a 22% reduction in projected FFS Hospital Inpatient Stay costs, for the Medicaid-only population, through the implementation of the STAR+PLUS model. MCOs achieving savings beyond 22% will be eligible for the STAR+PLUS Shared Savings Award and will be at risk for savings less than 22%.

Element	Description
	• NF Utilization Dis-incentive--The state is introducing a dis-incentive to prevent inappropriate admission to NFs. For the initial year the state will compare the MCOs annual rate of nursing home admissions for Medicaid-only STAR+PLUS enrollees to determine if there is a statistically significant increase in admissions from the prior state fiscal year. Those admitted and discharged within 120 days are excluded from the analysis. Upon gathering the data, the state will determine whether to include a NF utilization measure in either the Performance-Based Capitation Rate or the Quality Challenge Award for State Fiscal Years following 2012. • Additional Incentives and Dis-incentives--The state will evaluate all performance-based incentives and dis-incentive methodologies annually and in consultation with the MCOs. The state may then modify the methodologies as needed in an effort to motivate, recognize, and reward MCO for performance. State staff report they are currently reviewing the 5% risk and quality challenge as it can sometimes incentivize contradictory practices. They hope to streamline the process and help incentivize MCOs to increase client-centered practices.
18. Other Quality Management/ Improvement Activities	Texas has implemented STAR+PLUS in waves and the EQRO has taken advantage of this natural experiment in conducting studies. They have been able to construct focused studies with a pre-post program implementation design. They found that STAR+PLUS had a positive effect on treatment of COPD and receipt of beta-blockers; however, implementation of the STAR+PLUS program has had no effect on diabetes care. The EQRO has been working with HHSC to develop many future studies on the STAR+PLUS program. The next study the EQRO plans to conduct with the STAR+PLUS program is a study on the receipt of behavioral health care. They also plan to conduct a study on preventable hospitalization and STAR+PLUS members. A final paper will focus on the effects of STAR+PLUS on preventative care. Previously, the EQRO had conducted a focus study on dual eligible in the STAR+PLUS program and how participants' define quality of care.

ADL = activity of daily living
AIT = Administrative Interview Tool
CAHPS = Consumer Assessment Health Care Providers and Systems
CDPS = Chronic Illness and Disability Payment System
CHIP = Children's Health Insurance Program

CI = critical incident
COPD = chronic obstructed pulmonary disease
DFPS = Texas Department of Family and Protective Services
EQRO = external quality review organization
FFS = fee-for-service

FTE = full-time equivalent
HEDIS = Health Effectiveness Data and Information Set
HHSC = Texas Health and Human Services Commission
ICHP = Texas Institute for Child Health Policy
IT = information technology

LTSS = long-term services and supports

MCO = managed care organization
MLTSS = managed long-term services and supports
NF = nursing facility
PCP = primary care provider

PIP = performance improvement project
PPE = potentially preventable event
QA = quality assurance
QI = quality improvement
SP = service plan

SSI = Supplemental Security Income
ThLC = Texas Healthcare Learning Collaborative

APPENDIX H. WISCONSIN'S FAMILY CARE

Element	Description
MLTSS Program	Family Care
Lead Agency	Wisconsin Department of Health Care Services, Division of Long Term Care
Medicaid Authority	1915(b)/(c)
Inception	1999
Year LTSS Added	1999
Groups Enrolled	IDD, Aged and Physically Disabled
# Enrolled	33,141--IDD, Aged and Physically Disabled 9 MCOs (57 of 72 counties)
1. State Quality Oversight Infrastructure	The state has 9 MCO Oversight Teams composed of a CC and 1 or more MCQSs, and fiscal oversight staff. CCs oversee compliance and adherence to the MCO contracts and MCQS work on specific member issues. Three managers (2 regional managers and a manager of development and integration) supervise the 9 Oversight Teams. In addition to this team structure, the state has a MH Specialist, an RN Consultant, and an Employment Initiatives team who are available to support the Oversight Teams with specific member quality concerns or policy issues. They also provide support directly to the MCOs, when appropriate. This support includes training, capacity development, and integration of best practice related to MCO contractual requirements. NOTE: The state currently has currently 9 Oversight teams with of 1.5-3 FTEs per team. Resources may shift from team to team depending on MCO performance.
2. State IT Infrastructure for Supporting Quality Oversight	The MCO oversight teams use oversight database (SharePoint) to document issues and to track the resolution or remediation of these issues. In addition, they require each MCO to maintain an information system to collect, analyze, integrate, and reports data to support the objectives of the QM program. The MCOs' system provides information on grievances, appeals, and performance measures.
3. MCO Quality Oversight Responsibilities	MCO's have a governing board accountable for the MCO's QM program, a manager responsible for implementation of the QM plan with authority to deploy the resources as needed, and a QM committee. The QM committee includes both administrative and clinical personnel to facilitate communication and coordination between other functional areas of the organization that affect the quality of service delivery and clinical care.

Element	Description
	The MCO's is required to have a QM program that include processes to: • Monitor and detect under utilization and over utilization of services (MCOs are required to run submit IBNR reports to the state that compare authorized to delivered services. • Assess the quality and appropriateness of care furnished to members. • Have appropriate health professionals reviewing the provision of health services. • Monitor the performance of subcontracted providers. • Assure that licensed/certified providers and non-licensed/non-certified providers continuously meet required licensure, certification, or other standards and expectations, including caregiver background checks, education or skills training, and reporting of CIs to the MCO. • Provide for systematic data collection of performance and results make changes as needed. MCOs are required to create a means for MCO staff and providers (including attendants, informal caregivers, and health care providers) to participate in the QM program. If the MCO identifies deficiencies or areas for improvement, the MCO and the provider are required to take corrective action. MCO are required to conduct ongoing reviews that collects evidence to demonstrate that: • Appropriate risk assessments are performed on a timely basis. • Members participate in the preparation of the care plan and are provided opportunities to review and accept it. • MCPs address all participants' assessed needs (including health and safety risk factors) and outcomes. • MCPs are updated and revised in accordance with the applicable standards for timeliness and when warranted by changes in the members' needs and outcomes. • Services are delivered in accordance with the type, scope, amount, and frequency specified in the MCP. • Members are afforded choice among covered services and providers.
4. State Audits of MLTSS Program	The state Oversight Teams utilize several approaches to discover problems and monitor MCO improvement including review of: • Annual on-site Quality Review conducted by the EQRO. • IBNR reports that compare authorized to delivered services. • MCO or state level grievances and appeals. • Ombudsman program reports. • CI reports. The Oversight Teams also are required to: • Follow-up on individual member concerns. • Consult with the MCO on requests for use of isolation, seclusion and restrictive measures.

Element	Description
	The Oversight Teams are the state's primary resource for directing remediation and addressing individual member problems. The Teams regularly interact (monthly meetings and/or calls) with MCO staff and may identify concerns through this contact or direct observation. The MCO staff remediates individual member concerns and report the outcome to the Oversight Team. The Teams documents identified issues and concerns and the resolution or remediation of these issues in an oversight database (SharePoint) maintained by the state. Oversight teams use quality data to discover and remediate problems or issues, and look for trends or concerns happening at the MCO level. Every 2 months, all of the Oversight Teams meet and address issues occurring in various MCOs and regions to learn, share, and look at trends that may require additional quality or policy oversight and development. For example, the teams may review CIs reports to look for both statewide as well and MCO specific trends. The state focuses on "was the process followed" when evaluating the performance of the MCO. They use a no wrong door approach--quality can come from a number of places including MCO self-report. Sometimes the state gets calls from MCO providers but encourage providers to work with their MCO to resolve any issues. However, sometimes the state will meets with groups or providers that cross of multiple MCOs to discuss system-wide issues. The teams regularly interact with MCO staff (monthly meetings and/or calls) and may identify concerns through this contact or direct observation. The MCO staff remediates individual member concerns and report the outcome to the Oversight Team. The teams documents identified issues and concerns and the resolution or remediation of these issues in an oversight database (SharePoint) maintained by the state.
5. Performance Measures and Quality-Related Reports	The state has established a number of PMs in the 1915(c) waver to meet the waiver assurances. In addition, the MCO is required to specify 1 or more quality indicators specified for each PIP.
6. LTSS-Focused PIPs	MCOs are required to work with the state and EQRO to complete PIPs using a performance improvement model or method based on the state's defined process. While the PIP is in the planning stage, the MCO submits the study questions and the project aims or goals to be reviewed by the state or the EQRO. PIPs must be approved by the state. Each PIP must clearly define a focus area that relates to the demographic characteristics and to the prevalence and potential consequences of the desirable or undesirable conditions among the MCO's membership. The planned improvements should affect either a significant portion of the members or a clearly specified sub-portion. MCO's PIPs address a broad spectrum of key aspects for member care and services in both clinical and non-clinical focus areas. MCO's are not specifically required to conduct an LTSS-focused PIP, however, the focus area is selected on the based on members' needs, care, and services, or on the basis of member input.

Element	Description
	Each year, the MCO are required to make active progress on at least 1 PIP relevant to long-term care, and for those MCOs that include primary and acute care in the benefit package, 1 additional PIP relevant tor primary and acute care. The MCO may satisfy this requirement by actively participating in a collaborative PIP in conjunction with 1 or more MCOs. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of the PIP in aggregate to produce new information on quality of care every year. The state may require specific topics for PIPs and specify performance measures.
	MCOs are required to submit interim reports and document ongoing progress, and are required to report annually to the state on the status and results of each PIP.
7. Care Coordination	The ADRC does the initial LOC determination and then the MCO care coordinator (part of the IDT) conducts the CNA to develop the SP. The assessment includes a risk assessment conducted by the IDT to identify and mitigate risks. Members review and sign off on any risk identified during the assessment and service planning process.
	MCOs are required to conduct a face-to-face visit with a member during each quarter of the calendar year. After the first 6 months of enrollment, if MCO staff has established a relationship with the member staff can waive the minimum standard but a member must receive at least 1 face-to-face visit each year.
	Some MCOs have designated staff to work directly with to hospitals and NFs. This has helped to facilitate transitions back to a community setting. MCOs determine their caseload ratios. However, MCOs are required to submit a 3 year business plan that is approved by the state and the state will ask for rationale if the MCO's ratios vary significantly from the following state established norms: • 1:80 for nursed; • 1:40 for service coordinators.
	All MCO care coordinators must use the principals established in the state's RAD method to try to balance need with cost-effective service planning in the Family Care Program. Cost-effective means, "effectively supporting a desired outcome at a reasonable cost and effort." The RAD includes the following basic questions to consider and guidelines to follow.
	Questions: • What is the core issue/concern/need? • How does the core issue relate to the member's long-term care outcome? • Does the core issue affect the member's health or safety? • Does the core issue affect the member's independence, ADLs, or IADLs? • What options address the core issue while supporting the long-term care outcome?

Element	Description

	Guidelines:
	 • Member, guardian/legal representative and IDT staff identify and consider all potential options to address the core issue.
	   - Assess the current interventions in place.
	   - Review interventions from the past (e.g., what has worked previously?).
	   - Explore the role of natural supports (family, friends, and volunteers).
	   - Explore community resources that may be appropriate (supports and services that are not authorized or paid for by the MCO and are readily available to the general public).
	   - Address the core issue as if the member were not in a managed/long-term care program (e.g., how would this issue be met if you were not in the program?).
	   - Identify the member's ability and responsibility to address the core issue.
	   - Explore loaner programs and rental vs. purchase options.
	 • Review with the member which options are:
	   - Most effective in supporting the member's long-term care outcome?
	   - Most cost-effective in supporting the member's long-term care outcome?
	 • What organizational policy or guidelines apply?
	 • Negotiate with the member or guardian to reach a decision that best supports the member's long-term care outcome.
	 • If a service is to be authorized, explore the option for the member to self-direct this part of the POC.

8. 24-Hour Back-Up	The MCO is responsible for providing members with needed services 24/7 including immediate access to urgent and emergency services to protect health and safety, access to services in the benefit package and linkages to protective services.
9. CI Reporting and Investigation	The state defines a CI as a circumstance, event or condition resulting from action or inaction that is either: • Associated with suspected abuse, neglect, financial exploitation, other crime, a violation of member rights, or any unplanned, unapproved use of restrictive measures. • Resulted in serious harm to the health, safety or well-being of a member, substantial loss in the value of the personal or real property of a member. • Resulted in the unexpected death of a member. • Posed an immediate and serious risk to the health, safety, or well-being. The MCO is required to have designated staff to conduct CI investigations to determine: • Whether the CI occurred and the facts of the CI. • The type and extent of harm experienced by the member. • Any actions that were taken to protect the member to halt or ameliorate the harm. • Whether reasonable actions by the provider or others with responsibility for the well-being of the member could have prevented the incident. • Whether any changes in the MCO's or provider's policies or practices might prevent occurrence of similar incidents in the future.

Element	Description
	MCO are required to adopt and carry out policies governing the processes used for identification, review and analysis of each CI to ensure that CIs are reported to designated MCO staff by providers or by other MCO staff. If there is a potential violation of criminal law, MCOs are required to report this to local law enforcement authorities. CIs meeting protective service criteria are reported in accordance with the applicable statute to the appropriate authority. MCOs are also responsible for training MCO staff and providers regarding these polices. Timelines/Process: • CIs must be reported within 1 business day after the CI was discovered. • Within 3 calendar days of learning of the incident, the member or his/her guardian is notified of the CI (unless the guardian is a subject of the investigation). • A CI investigation is completed, by designated staff, within 30 days unless information or findings necessary for completion of the investigation cannot be obtained within that time for reasons outside of the MCO's control, in which case the investigation should be completed as promptly as possible. MCOs are required to have an ongoing program of collecting information about CIs, monitoring for patterns or trends, and using that information in the QM program. MCOs are required to submit a quarterly CI report to the state regarding member specific incidents (use a unique, traceable, HIPAA compliant identifier). The report includes: • Category/date of CI. • Setting where the incident occurred. • Description of the harm experienced by the member. • Description of the immediate actions taken to protect the member and to halt or ameliorate the harm. • Description of the underlying circumstance(s) that caused or allowed the incident to occur. • Date MCO incident analysis was completed. • Brief description of any policies or standard practices that have been or will be changed or adopted to prevent similar incidents in the future. Whenever egregious incidents occur, MCOs are expected to promptly report the incident to their respective Oversight Team. Minimally, the report must include the known facts of the incident and that member health and safety has been assured. The MCO is expected to conduct a full incident investigation and report back to the Oversight Team, as needed, and include all information in the quarterly report. The MCO's assigned MCQS reviews the MCOs reports using a standard Internal Review Tool. The state provides feedback to the MCO within 30 days of the receipt of the MCO's quarterly report. The feedback includes any concerns about the MCO's response to a CI. The state's CC may also discuss issue with the MCO's Quality Manager and provides guidance, recommendations, and negotiation of improvement/corrective action as needed.

Element	Description

	Additional Notes:
	• MCOs and its subcontracted providers are required to follow the state's written guidelines and procedures on the use of isolation, seclusion and restrictive measures in community settings, and follow the required process for approval of such measures.
	• Wisconsin has identified the following areas that that plan to work on to improve their CI system:
	  - Coordinate CI system with other state programs (FFS);
	  - Develop a system for state level aggregate data collection/analysis;
	  - Develop a standard mortality review process.

10. Mortality Review	MCOs are required to have a process to conduct mortality reviews. They must also report "unexpected deaths" on their quarterly report. However, the state does not conduct a state level review of mortality across the program.
11. EQRO Responsibilities	The state contracts with an EQRO to provide quality monitoring services-- referred to as the AQR includes the following activities: • QCR; • CMR; • Validation of PIPs. The EQRO also validates the MCO's performance measure data. The MCO must assist the EQRO in identifying and collecting information required carrying out on-site or off-site reviews and interviews with MCO staff, providers, and members. Every 3 years, the EQRO conducts a full review using the CMS protocol for QCR. In the second and third review years, the EQRO reviews the MCOs to reassess any unmet standards. The EQRO follows protocols to develop review standards and assessment tools and assesses standards with a "Met", "Partially Met" and "Unmet" ranking. The EQRO conducts annual CMRs of all MCOs. The EQRO reviews SPs and other documentation to assess whether MCOs comply with waiver and contractual requirements. The EQRO uses the NCQA sampling guidance of 1.5% of an MCO's membership or 30 records, whichever is greater. For this review, the EQRO assesses records using a "Met" or "Not Met" ranking. Each MCO also has an internal care plan review process that includes additional reviews of SPs and follow-up on findings. The EQRO produces 2 reports after the AQR is completed: • MCO Annual Quality Report--results of all review findings. • Detailed report of all findings at a member level.

Element	Description
	Once the state Oversight Team receives the EQRO report, they develop corrective action plans as needed with the MCO. The MCO is required to cooperate in further investigation or remediation, which may include: • Revision of a care plan. • Corrective action within a timeframe to be specified in the notice if the effect on the member is determined to be serious. • Additional review to determine the extent and causes of the noted problems. • Action to correct systemic problems that are found to be affecting additional members. Progress on corrective action plans is monitored monthly at meetings of the MCO and the Oversight Team. In addition to the individual MCO Annual Quality Reports, the EQRO prepares an overall program summary report annually.
12. Ombudsman/ Function	MCOs must have a Member Rights Specialist to help them through the appeals process. Members also have access to 1 of the state's Ombudsman programs. The state has 2 distinct state Ombudsman programs--1 for members 60 and older (covers more than the Family Care Program) and 1 for members 18-59 (just for Family Care). Ombudsmen also work with members to help to resolve an issue before it gets to the appeals process and to help members understand the appeals process. MCOs provide information about member rights specialist and outside ombudsmen programs via the member handbook and brochures fork the Ombudsman Programs. The Ombudsman Programs submit monthly reports to the state related to their activity associated with each of the MCOs in the state.
13. Experience of Care/ Satisfaction Surveys	The state has conducted a survey called PEONIS. State staff (or designees) conducted face-to-face interviews with 500 members. They are planning on making improvements to the tool and process in the future to improve the questions and the analysis to support QIs in the Family Care Program. In addition, MCOs are required to conduct member satisfaction surveys. The state provides the MCOs with core questions but does not set out standard requirements related to the administration of the tool. Some MCOs send out questionnaires annually, other conduct phone interviews, and others send out the questionnaire and then conduct a follow-up interview. The state is looking to develop a uniform process across all MCOs. At the state level, state staff has done some regional listening session and have created state advisory committees to gather participant feedback.
14. Membership Oversight	The state has created state advisory committee to gather participant feedback related to quality. In addition, MCO governing boards include members of the Family Care Program.

Element	Description
15. State Technical Assistance to MCOs	The MCO Oversight Teams (CC and MCQSs) provide technical assistance and support to the MCOs as needed. In addition, the state is also committed to providing basic training to MCOs regarding the requirements of the Family Care Program and other program specific area as needed.
16. MCO Report Cards on LTSS	None specified.
17. Financial Incentives, Penalties and Withholds	The state has established financial incentive payments for MFP enrollments, but do not have incentives for any quality-related activities or outcomes.
18. Other Quality Management/ Improvement Activities	None specified.

ADL = activity of daily living
ADRC = Aging and Disability Resource Center
AQR = Annual Quality Review
CC = Contract Coordinator
CI = critical incident

CMR = Care Management Review
CMS = Centers for Medicare and Medicaid Services
CNA = Comprehensive Needs Assessment
EQRO = external quality review organization
FFS = fee-for-service

FTE = full-time equivalent
HIPAA = Health Insurance Portability and Accountability Act
IADL = instrumental activity of daily living
IBNR = incurred but not reported
IDD = intellectual and developmental disabilities

IDT = Interdisciplinary Team
IT = information technology
LOC = level of care
LTSS = long-term services and supports
MCO = managed care organization

MCP = Member-Centered Plan
MCQS = Member Care Quality Specialist
MFP = Money-Follows-the-Person
MH = mental health
MLTSS = managed long-term services and supports

NCQA = National Committee on Quality Assurance
NF = nursing facility
PEONIS = Personal Experience Outcomes Integrated Interview and Evaluation System
PIP = performance improvement project
POC = plan of care

QCR = Quality Compliance Review
QI = quality improvement
QM = quality management

RAD = resource allocation decision
RN = registered nurse

SP = service plan

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

Reports Available

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

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

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

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

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

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

Quality in Managed Long-Term Services and Supports Programs
Executive Summary   http://aspe.hhs.gov/daltcp/reports/2013/LTSSquales.shtml
HTML   http://aspe.hhs.gov/daltcp/reports/2013/LTSSqual.shtml
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