
Application of Existing External Quality Review Protocols to Managed Long Term Services and Supports

This guidance document is intended to provide guidance to states on how to apply the revised protocols for External Quality Review (EQR) of Medicaid managed care organizations, released in 2012, to managed long term services and supports (MLTSS) programs. Although the protocols already apply to MLTSS generally, this document offers specific suggestions to make their application to long term services and supports (LTSS) clearer and provides suggestions, examples and illustrations to enable state agencies to explicitly include LTSS within the scope of their EQR contracts. Detailed recommendations and examples related to Protocol 1 – *Assessing MCO Compliance with Medicaid and CHIP Managed Care Regulations* are also included as an attachment.

Description of EQR Protocols

The Balanced Budget Act of 1997 requires state Medicaid agencies that contract with MCOs to develop a state quality assessment and improvement strategy consistent with Department of Health and Human Services (HHS) standards. It also requires HHS to develop protocols for use by independent, external quality review organizations (EQRO) to evaluate and report on the quality, timeliness of, and access to, care and services provided by Medicaid MCOs and prepaid inpatient health plans (PIHPs). Managed Long Term Services and Support (MLTSS) organizations, whether stand-alone or part of MCOs delivering a larger more integrated benefit package, are subject to these same requirements as long as the organizations providing the services meet the MCO or PIHP definitions outlined in 42 C.F.R. 438.2 <http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol4/xml/CFR-2007-title42-vol4-sec438-2.xml>.

There are eight protocols which provide detailed instructions to states and EQROs to guide their performance of EQR. Three EQR activities are mandatory, and the remaining five are voluntary. The protocols associated with each activity are detailed with respect to the review *process*; however, they leave decisions to the states about the content and extent of the reviews.

The eight protocols are:

- Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations (Mandatory EQR Activity)
- Protocol 2: Validation of Performance Measures Reported by the MCO (Mandatory EQR Activity)
- Protocol 3: Validating Performance Improvement Projects (Mandatory EQR Activity)
- Protocol 4: Validation of Encounter Data Reported by the MCO (Voluntary EQR Activity)
- Protocol 5: Validation and Implementation of Surveys (Voluntary Activity)

- Protocol 6: Calculation of Performance Measures (Voluntary EQR Activity)
- Protocol 7: Implementation of Performance Improvement Projects (Voluntary EQR Activity)
- Protocol 8: Conducting Focused Studies of Health Care Quality (Voluntary EQR Activity).

For the most recent protocols, always refer to <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

General Guidance on Application to MLTSS

States should consider the following when interpreting the protocols generally:

- Throughout the protocols, there are references to the EQRO technical report to the state. Information extracted from these reports, including reports on MLTSS, may be included in the annual Secretary’s Report on the quality of care in Medicaid and CHIP.
- Whenever the protocols list providers or provider types, states should consider the relevance of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and community-based LTSS providers.
- Whenever the protocols list services, states should consider the applicability to LTSS.
- Throughout the protocols and supporting data collection tools, the current language and examples reflect a medical orientation. Where such tools and examples are provided, states and their EQROs should consider how to modify them to apply to LTSS, which are non-medical services that assist individuals in performing activities of daily living (e.g. eating, dressing, getting in and out of bed, toileting, bathing) or instrumental activities of daily living (e.g. taking medications, shopping, handling finances, housekeeping, etc.) and that support individuals to live independent, inclusive lives and participate fully in community settings, including employment.

Use of Terms within the Protocols

The protocols use a variety of terms that may be narrowly construed to reflect medical services. Below are expanded definitions of certain terms that states should consider in reviewing and applying the protocols to LTSS.

1. Care plan

The person-centered, written document that identifies what services and supports the beneficiary needs to achieve and maintain their best physical, mental, and social well-being. The service plan, which authorizes services, may be included within the care plan.

2. Health care

All Medicaid services covered in the state plan or under approved waivers in any setting, including medical care, behavioral health care and LTSS.

3. Individuals with special health care needs

Individuals with greater than average health care needs, including people in fragile health; people with multiple chronic conditions; people with complex health care needs and people who may be healthy but as a result of physical, intellectual or developmental disabilities need LTSS.

4. MCO

All managed care organizations, including PIHPs under a Medicaid and/or CHIP program, including comprehensive managed care plans that provide long term services and supports and stand-alone managed LTSS that meet the definitions outlined in 42 C.F.R. 438.2.

5. Medical records

All medical, behavioral health and long-term care histories, assessments and care plans; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical care, behavioral health care, and LTSS documentation in written or electronic format; and analyses of such information.

6. Outcomes

Changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

7. Protections

Referred to as “member rights” in managed care and “human rights” in disability services, and “consumer protections” in other settings. Protections include rights to control one’s life; freedom from exploitation, restraint, punishment, seclusion, etc. as they have been articulated in the Americans with Disabilities Act of 1990 (ADA). In addition, these protections include the right to information, grievance and appeal rights, the right to participate in decisions about services and treatments, including the right to refuse treatment.

8. Service plan

The written document that specifies the authorized services and supports that are to be furnished to meet the needs of a beneficiary.

Recommendations for the Application of Each EQR Protocol to MLTSS

EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations (Mandatory EQR Activity)

Protocol 1 is for a mandatory activity that evaluates MCO compliance with federal quality standards outlined in the BBA and related state requirements established in law, regulation or contract terms.

There are several sections of the protocol, consistent with the general recommendations described above, that states should apply to managed LTSS. In addition, states should consider the new parity requirements for behavioral health conditions¹ and the states’ own statutory, regulatory and contractual requirements for protections for vulnerable individuals, including

¹ Mental Health Parity and Addiction Equity Act of 2008, MHPAEA, Pub.L. 110-343 requires group health insurance plans (those with more than 50 insured employees) and Medicaid managed-care programs that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan. See State Medicaid Director Letter for further guidance <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

human rights protections and member or consumer rights as defined above and other requirements for MLTSS quality, accessibility and service.

The protocol lists a number of types of information that would be useful during a preliminary document review. States should include a review of LTSS providers as part of their review of the number of providers by type within the network, including HCBS LTSS and nursing and ICF/IID facilities. Furthermore, in considering providers, states' managed care contracts should define expectations, such as qualifications, for self-directed workers –workers employed directly by beneficiaries or through Fiscal Agents, in the context of self-direction programs. States should consider how the external quality review should assess the compliance of self-direction programs with federal and state requirements.

The attachments to Protocol 1 are intended as suggestions for documenting the compliance review and questions for interviews. Throughout the attachments, while respecting the “nonduplication” provisions of the managed care regulations, states should consider expanding the scope of the review to cover compliance with federal and state requirements beyond those specified 42 C.F.R. 438, to include other state statutory, regulatory or contractual requirements related to the following areas. CMS has posted on Medicaid.gov two documents that provide specific suggestions and additions to the attachments to Protocol 1 for documents to review and interview questions that address the areas below:

- Accessibility, including physical accessibility of service sites and medical and diagnostic equipment, accessibility of information (e.g. Section 508 of the Rehabilitation Act [29 U.S.C. § 794d] compliance with web-based information, literacy levels of written materials, alternate formats) and other accommodations , such as providing extra time for individuals to dress and undress or transfer to examination tables and extra time with the practitioner in order to ensure the individual is fully participating and understands the information.
- Availability and use of HCBS as alternatives to institutional care, such that individuals can receive the services they need in the most integrated setting appropriate. .
- Credentialing or other selection processes for LTSS providers, including when applicable, in the context of self-direction programs, such as verification of completion of criminal background checks.
- Person-centered assessment, person-centered care planning, service planning and authorization, service coordination and care management for LTSS, including authorization/utilization management for LTSS and any beneficiary rights or protections related to care planning and service planning such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.
- Integration of managed medical, behavioral and LTSS.

EQR Protocol 2: Validation of Performance Measures Reported by the MCO (Mandatory EQR Activity)

Protocol 2 is for a mandatory activity that validates performance measures reported by the MCO to the state. It provides guidance to the EQRO for evaluating the accuracy of reported performance measures and evaluating how well the MCO followed the state's rules for calculating the measures. This protocol rests upon clearly specified performance measure

reporting requirements in the state’s MCO contracts. Guidance below relates to specific protocol activities.

1. Activity 1 Step 2 “Assess the Integrity of the MCO’s Information System”

Protocol 2 provides examples of various claim types and encounter data, and instructs the EQRO to note specific information about each type of claim/encounter data captured. States should also consider LTSS, including, as applicable, specific subsets of LTSS such as personal care services, equipment and supplies, transportation, home modifications, supported employment and other waiver services, when evaluating the accuracy and completeness of data used to measure each service. In addition, states should consider the specific data that MCOs capture from LTSS claims and encounters, which may differ from the data captured from medical claims. For example, certain LTSS may reflect hours as the relevant unit of service, rather than numbers of visits, admissions or days.

2. Activity 2 Step 1 “Review Information Systems Underlying Performance Measurement”

Protocol 2 lists typical primary data sources that can be used to validate electronic data on membership, service utilization, lab results and provider information. In addition to this list, states should include LTSS claims and encounters, case management systems and any other data systems that capture information from beneficiary care plans or service plans as additional primary data sources that the EQRO should review.

EQR Protocol 3: Validating Performance Improvement Projects (Mandatory EQR Activity)

Protocol 3 is for a mandatory activity that validates performance improvement projects (PIPs) conducted by MCOs. The purpose of the protocol is to guide the EQRO in assessing the validity and reliability of a PIP. It includes three activities: (1) assessing the study methodology, (2) verifying the study findings and (3) evaluating the overall validity and reliability of the study results. The specific type and number of required PIPs may be established in the state’s contracts with its MCOs. States should consider requiring PIPs or PIP topics that are uniquely relevant to managed LTSS.

The following are sections of the protocol where states should specifically consider its application to LTSS.

1. Activity 1 Step 1 “Assess the Study Methodology”

The protocol states that the PIP, over time, should address a broad spectrum of enrollee care and service. It lists 8 examples of sub-populations and dimensions of care and services. Although these are just examples, states should also include, where applicable, adults with physical disabilities, people with intellectual and developmental disabilities and people with dual eligibility who use LTSS as additional enrollees whose care and services should be addressed by the PIP.

2. Activity 1 Step 4 “Review the Selected Study Indicators”

In “Notes to Reviewers,” the protocol defines outcomes as “changes in patient health, functional status, or satisfaction resulting from the PIP.” States should additionally consider avoidable hospitalizations or Emergency Department visits, which can serve as indicators of care coordination, reductions in institutional placement or length of stay, individual choice and control, and individual goal achievement (for example, employment or participation in the community) as important outcomes.

3. Activity 1 Step 6 “Review the Data Collection Procedures”

In the section of the step addressing the appropriateness of the PIP's data collection procedures, the protocol suggests the EQRO consider whether the study design clearly specifies the sources of data. The six data sources listed are: (1) Beneficiary medical records, (2) Tracking logs, (3) Encounter and claims systems, (4) Provider interviews, (5) Beneficiary interviews, and (6) Surveys. States that use electronic visit verification (EVV) systems² for LTSS should consider those systems as a potential data source.

In the same section, there are questions about data collected through automated vs. manual systems. The examples given include inpatient care, primary care, specialty care, ancillary services and EHR data. States should also consider automated sources of information about LTSS, such as EVV and case management systems, and manual sources, such as individual assessments and care and/or service plans.

4. Protocol 3 Attachment

Attachment A is a PIP Review Worksheet, which serves as a guide for conducting and documenting the validation of a PIP. There is a checkbox on the type of delivery system (to which the PIP applies). States should add "managed LTSS plan" to the list of delivery systems.

EQRO Protocol 4: Validation of Encounter Data Reported by the MCO (Voluntary EQRO Activity)

Protocol 4 is for a voluntary activity that validates encounter data reported by the MCO. Much of this protocol parallels the process outlined in Protocol 2 for the validation of performance measures reported by the MCO. Encounter reporting for home- and community-based LTSS is more incomplete and less standardized relative to medical care encounters. States should establish standards for encounter reporting in their contracts, including defining what constitutes a reportable encounter. In doing so, states should consider the various types of LTSS, the relevant service units, and how they might be reflected as encounters.

In the introductory section of the protocol, encounter data is described as "data (that) provide substantially the same type of information that is found on claim forms (UB-04 or CMS 1500)..." States should recognize that this description applies for medical claims and encounters. LTSS claims and encounters are likely to differ. For example, medical claims typically specify dates of service or, for inpatient stays, dates of admission and discharge. They always include diagnosis. Many LTSS claims may specify a period of service, for example a month during which some number of hours of personal care service were delivered, and there may not be an associated diagnosis. Claims for other services, such as residential services, or home modifications, may include information not generally included on medical claims, and may exclude information that is universally included on medical claims.

The protocol consists of five activities, one of which is a review of medical records for confirmation of findings of the analyzed encounter data. Because LTSS encounters will likely not be reflected in the primary care medical record, states should consider the broader definition of medical record as inclusive of all individual health, behavioral or other long-term services and supports documentation such as might be found in case management systems, assessments and care and/or service plans.

² Electronic Visit Verification is a telephone and computer-based system that electronically verifies that service visits occur and documents the precise time service provision begins and ends. EVV is used by some home- and community-service providers and payers to ensure accountability of service providers in a distributed environment.

1. Activity 2 Step 1 “Review the MCO Information System Capabilities Assessment (ISCA) and Activity 3 Step 1 “Develop a Data Quality Test Plan”

This section of the protocol provides guidance on developing a data quality test plan based on the potential vulnerabilities of the data. The protocol gives examples of types of potentially missing encounter data. “MCOs that provide payment for ‘bundled’ services, such as prenatal care, or capitates providers, may not receive complete information from those providers.” Among HCBS LTSS, there are different contributors to missing and inaccurate data. In some instances, services such as home modifications or shared living do not lend themselves to capture as “encounters.” In the case of home modifications, there may be no contact between the provider and recipient of services. In the case of shared living, the service is continuous, and other units of measurement, such as hours or days of service, may be more descriptive. In other instances, payment systems, such as self-directed services and supports with a budget, may result in services that are unreported or under-reported. A common approach to payment for LTSS is to pay based on a claim for a span of time, such as a month, where individual services may not be dated or separately reported. States, understanding their own delivery and payment systems, should work with their EQROs to identify and mitigate data vulnerabilities.

2. Protocol 4 Attachments

Attachment A is a set of encounter data tables that lists encounter types for identifying areas of concern. It includes office visit, mental health/substance abuse office visit, dental office visit, inpatient, inpatient mental health/substance abuse and other. States should add additional encounter types, as defined in state contracts as reportable encounters, including relevant LTSS.

Subsequent tables list specific data elements for documentation of concerns. Data elements include enrollee ID, Plan ID, Provider ID, principal diagnosis, procedure code, date of service and units of service. States should work with their EQROs to add data elements that are relevant to the way they collect LTSS encounters.

EQR Protocol 5: Validation and Implementation of Surveys (Voluntary EQR Activity)

Protocol 5 is for a voluntary activity that validates previously-conducted surveys, or the implementation of surveys³. The protocol includes 8 activities related to survey implementation: (1) Identify survey purpose(s), objective(s) and intended use; (2) Select the survey instrument; (3) Develop the sampling plan; (4) Develop a strategy to maximize the response rate; (5) Develop quality assurance plan; (6) Implement the survey; (7) Prepare and analyze data obtained from the survey; (8) Document the survey process and results. The protocol presents a parallel set of steps for validating previously-conducted surveys. Like Protocol 2 for the validation of performance measures, Protocol 5 does not require specific survey instruments, topics or targets.

1. Activity 2 “Select the Survey Instrument”

The protocol provides instructions for selecting a survey instrument, and addresses the options of using an existing instrument, adapting an existing instrument or developing new instrument. States should be particularly mindful of the caution about an existing

³ CMS is currently in the process of testing a consumer satisfaction survey or experience of life survey specifically designed for users of LTSS living in the community. States with an MLTSS program may want to consider that survey in the future.

instrument that has not been validated for Medicaid or CHIP populations, because pre-existing, validated survey instruments may not have been validated for a particular subpopulation, such as people with intellectual and developmental disabilities. Use of survey instruments not validated in the target population may not yield valid or reliable results.

2. Activity 4 “Develop a Strategy to Maximize the Response Rate”

The protocol provides guidelines for developing a strategy to maximize the response rate. It discusses various survey methods, such as telephone, mail and interactive voice recognition, methods which are effective in the general population. It specifically discourages personal interviews. However, for some population segments, such as people with intellectual and developmental disabilities, people with dementia or cognitive impairments or those with serious mental illness, personal interviews may be the only effective survey approach.

The protocol lists a number of strategies to improve response rates, including providing a cover bulletin that emphasizes the survey sponsorship, using personalized correspondence with respondents, providing stamped return envelopes and using follow-up contacts. States should consider strategies that accommodate proxy respondents, assisted responses and other methods that take into account the capacity of the target population to respond.

EQR Protocol 6: Calculation of Performance Measures (Voluntary EQR Activity)

Protocol 6 is for a voluntary activity for the calculation of MCO performance measures by the EQRO. This protocol parallels many of the activities contained in Protocol 2 for the validation of performance measures calculated by the MCO and Protocol 4 for the validation of encounter data reported by the MCO.

1. Page 2 Activity 2 “Calculate Measures”

The protocol states that the EQRO may need to conduct medical record review to obtain necessary data. Because LTSS encounters will likely not be reflected in the primary care medical record, states should consider the broader definition of medical record as inclusive of all individual health, behavioral or other long-term services and supports documentation such as might be found in case management systems, assessments and care and/or service plans and care notes.

EQR Protocol 7: Implementation of Performance Improvement Projects (Voluntary EQR Activity)

Protocol 7 is for a voluntary activity for the implementation of optional PIPs for the state. This protocol parallels and references many of the activities contained in Protocol 3 for the validation of PIPs performed by MCOs. Most of the details of the activities are incorporated from Protocol 3 by reference.

1. Activity 6 “Reliably Collect Data”

The protocol lists a number of potential data sources. States should consider adding case management systems, EVV systems, and other data sources that provide information about LTSS.

EQR Protocol 8: Conducting Focused Studies of Health Care Quality (Voluntary EQR Activity)

Protocol 8 is for a voluntary activity for the conduct of focused studies at the request of the state. The process of conducting focused studies mirrors most of the activities of Protocol 3 for validating PIPs and Protocol 7 for implementing PIPs. Most of the details of the activities are incorporated from Protocol 3 by reference. This protocol may be particularly useful to states that wish to conduct special studies focusing on LTSS.

States and other interested parties will also find additional information about MLTSS at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html>.

Resources

Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). 2012. *External Quality Review Protocols*. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). 2012. *External Quality Review Toolkit for States*. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Toolkit.pdf>

Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). 2013. *Guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs*. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html>.

Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). 2010. *Understanding Medicaid Home and Community Services: A Primer. Appendix: Medicaid HCBS Quality*. <http://aspe.hhs.gov/daltcp/reports/2010/primer10.pdf>

Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). 2011. CMS Manual System. Pub. 100-11 *Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 10 – Quality Assessment and Performance Improvement*. <http://www.cms.gov/Medicare/Health-Plans/pace/downloads/R1SO.pdf>

Department of Health and Human Services Office of Inspector General. 2008. *External Quality Reviews in Medicaid Managed Care*. <https://oig.hhs.gov/oei/reports/oei-01-06-00510.pdf>

Department of Justice Civil Rights Division. *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* http://www.ada.gov/olmstead/q&a_olmstead.pdf

Paul Saucier, et. al. TruvenHealth Analytics for Centers for Medicare and Medicaid Services, July, 2012. *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf

Debra J. Lipson, Jenna Libersky, Mathematica Policy Research; Lynda Flowers and Wendy Fox-Gage, AARP Public Policy Institute, July 2012. *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*. 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

EQR PROTOCOL 1 – ASSESSING MCO COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS

Attachment A: Compliance Review Worksheet

The content and documents identified for review within *Attachment A: Compliance Review Worksheet* can be applied to Long Term Services and Supports (LTSS), including Home and Community Based Services (HCBS) with minimal adjustment to the existing resource list. When evaluating all documents, the EQRO should consider the full spectrum of services provided or arranged by the organization, including LTSS. For example LTSS services may include (but are not limited to):

- Institutional
 - Nursing Facilities
 - Intermediate Care Facilities for People with Intellectual or Developmental Disabilities (ICF/IDD)
 - Psychiatric Residential Treatment Facilities (PRTF)
- Non-institutional based LTSS services
 - Case Management (i.e. supports and service coordination),
 - Homemaker,
 - Home Health Aide,
 - Personal Care,
 - Adult Day Health Services,
 - Habilitation (both Day and Residential),
 - Respite Care and
 - Any other approved state specific services which assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

In addition to this consideration, the following specific documents or additional state regulations should be reviewed specifically for LTSS. Language from the original Attachment A: Compliance Review Worksheet document is in plain text. *Additions or revisions to language specific to LTSS are noted in underlined italics.* The organization and numbering from the original protocol attachment has been preserved for ease of integration.

Subpart C:--Enrollee Rights and Protections

Federal Regulation Source(s)	State Regulation Source(s)	Applicable MCO Documents
438.100 Enrollee rights	<p>10) <u>Whether or not the State agency has established additional rights for the protection of beneficiaries utilizing HCBS benefits</u></p> <p>11) <u>Whether or not the State agency has established requirements for materials to be available in alternative formats</u></p>	<ul style="list-style-type: none"> • Medicaid/CHIP enrollee marketing materials, <u>including alternate formats, such as Braille, audio, video, large print</u>
438.206: Availability & Accessibility of services	<p>1) The State agency has required the MCO to adhere to any explicit standards for provider network adequacy, such as prescribed primary physician/enrollee ratios, specialist/enrollee ratios, <u>LTSS provider availability</u></p> <p>2) The State agency has in place any time or distance standards for beneficiary travel to access covered services in Medicaid/CHIP fee-for-service or HCBS</p> <p>4) <u>There are any State laws or contract provisions requiring the availability of HCBS as alternatives to institutional care</u></p> <p>5) <u>There are any State laws or contract provisions addressing physical accessibility of services</u></p>	
438.208: Coordination and continuity of care	<p>1) Definition/specifications used by State to identify individuals with special health care needs (SHCNs) <u>including Individuals with greater than average health care needs, including people in fragile health; people with multiple chronic conditions; people with complex health care needs and people who may be healthy but as a result of physical, intellectual or developmental disabilities need LTSS</u></p> <p>8) <u>Any State rules addressing person-centered assessment, person-centered care planning, service planning and authorization, service coordination and care management for LTSS</u></p> <p>9) <u>Any State rules addressing the integration of medical, behavioral and LTSS in assessments, care planning, service planning, authorization, service coordination and care management practices</u></p>	

Subpart D:--Quality Assessment and Performance Improvement

Federal Regulation Source(s)	State Regulation Source(s)	Applicable MCO Documents
438.214: Provider Selection		<ul style="list-style-type: none"> • <u>Policy and Procedures related to credentialing, recredentialing and/or verification processes used for LTSS providers.</u> • <u>Contract requirements for Co-Employer and/or Fiscal Agent verification of self-directed employees' qualifications, including meeting background check requirements.</u> • Provider/Contractor files, 15-20 individual health care professional files, and 15-20 institutional <u>(including acute and LTC) provider files, 15-20 files of HCBS providers of LTSS services which document the selection process including verification of provider qualifications.</u>
438.240: Quality Assessment and Performance Improvement Program		<ul style="list-style-type: none"> • <u>Projects or measures of LTSS</u>
438.242: Health Information Systems		<ul style="list-style-type: none"> • <u>LTSS encounter data</u>

Subpart F:--Grievance System

Federal Regulation Source(s)	State Regulation Source(s)	Applicable MCO Documents
438.402 General Requirements	4) <u>What components of a service plan can be appealed</u>	<ul style="list-style-type: none"> • <u>Grievance and Appeals Policy and Procedures</u> • <u>Enrollee Handbook</u>
438.420: Continuation of Benefits While the MCO or PIHP Appeal and the State Fair Hearing are Pending		<ul style="list-style-type: none"> • <u>Authorization and/or claims detail showing continuation of service during appeal process</u> • <u>Medicaid/CHIP Enrollee Handbooks</u> • <u>Medicaid/CHIP Enrollee Orientation Curriculum</u>

EQR PROTOCOL 1 – ASSESSING MCO COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS

Attachment D: Compliance Interview Questions

The content and questions identified within *Attachment D: Compliance Interview Questions* can be applied to Long Term Services and Supports (LTSS) with relative ease. To support an inclusive interview process, the following additions and/or revisions to existing questions are designed to elicit additional information regarding how the organization provides, delivers and oversees the LTSS benefits within its programs. Language from the original Attachment D: Compliance Interview Questions document is in plain text. Additions or revisions to language specific to LTSS are noted in underlined italics. The organization and numbering from the original protocol attachment has been preserved for ease of integration.

MCO Leaders

Enrollee right to respect, dignity, privacy (438.100)

1. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights such as treatment with respect, dignity, and consideration for privacy and confidentiality of information? Are there any additional considerations made for providers of LTSS, where services may be of a more intimate nature or occur in a more isolated setting?
Provide examples.

Enrollee right to receive information on available treatment options (438.100 and 438.102)

1. How does the MCO ensure that providers share information on available treatment options and alternatives with enrollees? Does this include alternatives and options that are outside, as well as within, the Medicaid contract's scope of benefits? How does the MCO ensure providers share information about HCBS as alternatives to institutional care?

Availability of services (438.206)

4. What assumptions and methodologies are used to project the number, type (in terms of training, experience, and specialization) and location of LTSS providers necessary to serve its anticipated Medicaid enrollees?
5. If the state has established access requirements for LTSS, how does the plan evaluate its current network in comparison to the requirements? Are there any areas where the requirements are not met? If so, how is the plan remedying these gaps?

Cultural Considerations (438.206(c)(2))

2. What have been the MCOs efforts to promote services to enrollees with limited English proficiency and those with low literacy? How does the MCO maintain and make available information on all languages (including both spoken and signed) used by providers of LTSS?
3. How are call center staff made aware of MCO beneficiaries' needs so that verbal communication can be conducted in a manner easily understood by the beneficiary? For example, volume or speed of speech.

Coordination and continuity of care (438.208)

7. What processes are used to coordinate services for enrollees? Are there different types of care coordination mechanisms for different types of enrollees? Are there different types of care coordination mechanisms for different services, (acute, primary and LTSS)? If so, what are these?
8. If your MCO establishes separate coordination of care for medical services, LTSS and mental health and substance abuse services, how does it ensure exchange of necessary information between care coordinators? How does it ensure information exchange among providers?
9. How are staff trained in the processes and tools required to facilitate integrated medical, behavioral and LTSS assessment, care planning, service planning and authorization activities?

Coverage and Authorization of Services, Including Emergency and Post-Stabilization Services (438.210 and 438.114)

4. Are emergency back-up plans created for all enrollee's? If not, how is the need for an emergency back-up plan determined? How is the emergency back-up plan shared with all appropriate parties?
5. Are certain LTSS providers/provider types contracted specifically for after-hours/urgent/emergent need? If so, what types? How were these types determined?

Provider selection and non-discrimination (438.214 and 438.12)

2. What is the basis or criteria used to determine institutional or other non-individual practitioner (including LTSS) participation in the MCO's network?
3. What types of providers are subject to the MCO's Credentialing process? How are provider qualifications (including background check requirements) verified for provider types not subject to the Credentialing process?

Quality assessment and performance improvement program (438.240)

2. How does your MCO assess the quality and appropriateness of care, including LTSS, furnished to enrollees with special health care needs?

Health information systems (438.242)

2. What processes are in place to obtain data from all components of your network (e.g. health care facilities, physician, laboratories, and LTSS)? To what extent does your MCO require and receive data in standardized formats? Are there any components of your network from which you do not receive standardized (or any) information on services?

Grievance systems (438.404(b)(7))

1. Does the enrollee's right to have benefits continue pending resolution of the appeal, the process to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services differ between medical and LTSS? If so, how? Are there any special considerations required for continuation of LTSS pending resolution of an appeal?

MCO Information Systems Staff

Coordination and continuity of care (438.208)

1. How does the MCOs information system integrate medical, behavioral and LTSS assessments, care planning, service planning and authorization information and processes?

Quality Assessment and Performance Improvement Program Staff

Enrollee rights (438.100)

1. How is the enrollee's right to be free from restraint or seclusion monitored for enrollees receiving LTSS?

Availability of services (438.206)

1. How frequently does the MCO evaluate the volume and enrollee access to LTSS services? What factors are used in evaluation of the LTSS network?

Provider selection (438.214)

3. What types of information does the quality improvement program provide to support the evaluation of LTSS provider qualifications?

Quality assessment and performance improvement program (438.240)

4. How does your MCO assess the quality and appropriateness of care, including LTSS, furnished to enrollees with special health care needs? Provide examples.
9. How is LTSS incorporated in performance improvement projects? What performance improvement projects currently involving LTSS are in place?
10. What interventions are used or are anticipated to be used to improve LTSS quality? How will the interventions be evaluated for effectiveness? How will improvement be sustained or increased?

Provider/Contractor Services Staff

Enrollee rights (438.100)

1. How does the MCO inform its LTSS, individual and institutional providers about enrollee rights and responsibilities? How does the MCO monitor for compliance with these rights by its providers?
4. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights such as treatment with respect, dignity, and consideration for privacy and confidentiality of information? Are there any additional considerations made for providers of LTSS, where services may be of a more intimate nature or occur in a more isolated setting? Provide examples.
6. Describe the MCO's credentialing, verification and oversight processes for primary care providers, other health care professionals, LTSS and institutional providers. What is encompassed by reviews and evaluations of these providers? Do these processes involve visits to the providers' care delivery sites?
10. How does the MCO inform its LTSS, individual and institutional providers about enrollee rights to

service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion from an appropriately qualified health professional? How does the MCO monitor for compliance with these rights by its providers?

Availability of services (438.206)

1. Describe the MCO credentialing, re-credentialing process, and verification processes. Is this different for Medicaid and/or LTSS providers?
5. How does the MCO evaluate the expected utilization of institutional care in comparison with the use of HCBS as an alternative?
6. Does the MCO maintain accessibility information on its LTSS providers? If so, how is this maintained and shared with enrollees?
7. How does the MCO encourage the promotion of culturally competent service delivery by LTSS providers?
8. Are there any limits to choice of LTSS providers?

Timely access to service (438.206(c))

6. Are MCO/PIHP and provider services available 24 hours a day, 7 days a week, when medically or otherwise necessary to meet the enrollee's needs? Are certain LTSS providers/provider types contracted specifically for after-hours/urgent/emergent need? If so, what types? How were these types determined?
7. Are providers included in developing beneficiary emergency back-up plans? If not involved in the development of the plan, how are they made aware of their responsibility for emergency back-up?

Coordination and continuity of care (438.208)

1. How are primary care providers serving enrollees with special health care needs made aware of and involved in procedures for:
 - a. Assessing individuals with special health care needs?
 - b. Ensuring that treatment plans address the needs identified by the assessment?
 - c. Assuring appropriate use of specialists?
 - d. Coordinating primary care services with care provided by other MCO's and PIHPs serving the enrollee?
 - e. Coordinating care with LTSS providers?
2. How are specialty providers serving enrollees with special health care needs made aware of and involved in procedures for:
 - a. Assessing individuals with special health care needs?
 - b. Ensuring that treatment plans address the needs identified by the assessment?
 - c. Coordinating care with LTSS providers?
3. How are LTSS providers serving enrollees with special health care needs made aware of and involved in procedures for:
 - a. Assessing individuals with special health care needs?
 - b. Ensuring that treatment plans address the needs identified by the assessment?
 - c. Coordinating care with primary care and specialty providers?

Coverage and authorization of services (438.210)

4. Does the MCO contract with all LTSS provider types identified in the State's benefit package? If not, what provider types are not contracted? How are enrollees' needs met in lieu of this service availability?
5. Are there any universal service limitations on LTSS? If so, what are they, and how were these determined?

Provider selection (438.214)

4. Describe the MCO's/PIHP's processes for selecting and monitoring institutional and other non-practitioner network providers (including LTSS). What information is reviewed as a part of this process? Are site visits made? When and how often?
9. How does the MCO verify the skills and requirements of LTSS providers, including self-directed support options? (ie. Background checks, exclusions, certifications and/or licensures)

Health information systems (438.242)

1. Does the MCO have data collection requirements for LTSS providers, health care facilities and physicians? How are the requirements relayed to these organizations and individuals?

Sub contractual relationships and delegation (438.230)

5. Does the MCO delegate any of its activities to LTSS providers? If so, how is the provider's ability to carry out delegated activities determined and monitored?

Quality assessment and performance improvement program (438.240)

1. How does the MCO monitor LTSS provider quality, appropriateness of care, compliance with state and plan requirements and enforce corrective action when necessary?

Enrollee Services Staff

Enrollee right to information (438.100 and 438.10)

9. Are there any benefits that an enrollee is entitled to under the Medicaid program, including LTSS benefits, but that are not made available through the MCO contract? What are those benefits? How are enrollees made aware of the Medicaid program benefits that are outside the scope of services available through the MCO?
14. How does the MCO ensure that informational and instructional materials intended for enrollees and potential enrollees are easily understood by those with a variety of cognitive and intellectual capabilities?
15. How does the MCO make available to its enrollees information regarding provider appeal rights regarding coverage of a service?

Enrollee right to respect...dignity, and ...privacy (438.100)

1. How does the MCO ensure that its own facilities and those of its affiliated providers comply with enrollee rights such as treatment with respect, dignity, and consideration for privacy and confidentiality of information? Are there any additional considerations made for providers of LTSS, where services may be of a more intimate nature or occur in a more isolated setting?

Provide examples.

Utilization Management Staff

Availability of services (438.206)

1. How frequently does the MCO evaluate the volume and enrollee access to LTSS services? What factors are used in evaluation of the LTSS network?
2. How does the MCO evaluate the expected utilization of institutional care in comparison with the use of HCBS as an alternative?

Coverage and authorization of services (438.210)

11. Does the authorization process differ between acute and primary services and LTSS? If so, how?

Quality assessment and performance improvement program (438.240)

2. How does the MCO monitor LTSS utilization patterns?

Grievance system – general requirements (438.402)

3. Does the MCO's grievance and appeal system differ for LTSS vs. acute and primary care services? If so, how?

Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending (438.420)

1. What happens to enrollee benefits once continuation of benefits has been denied by the MCO, and an appeal has been filed by the enrollee, the treating physician or other provider, including providers of LTSS? Are there any mechanisms in place to continue the benefits pending the outcome of the appeal and if so, under what circumstances? How are enrollees notified of this mechanism?

Medical Directors

Coverage and authorization of services (438.210)

5. What mechanism does the MCO use to assure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollees' condition or disease or by a professional with expertise in serving special populations (e.g. Developmental Disabilities), in special services (e.g. Vocational Rehabilitation), or with other LTSS expertise as appropriate?
7. How does the MCO apply the definition of 'medically necessary services' to LTSS for activities that support age-appropriate growth and development and/or the ability to attain, maintain or regain functional capacity?

Case Managers and Care Coordinators

Enrollee rights (438.100)

1. How are the available options for LTSS identified and presented to enrollees?
2. How are enrollees engaged in decisions about the use of LTSS?

3. How is the enrollee's right to be free from restraint or seclusion monitored for enrollees receiving LTSS

Availability of services (438.206)

1. How does the MCO evaluate the expected utilization of institutional care in comparison with the use of HCBS as an alternative?

Coordination and continuity of care (438.208)

11. If the MCO establishes separate coordination of care for medical services, LTSS and mental health and substance abuse services, how does the MCO ensure exchange of necessary information between providers?
12. How is post-acute care coordinated?
13. How are LTSS providers involved in person-centered assessment, person-centered care and service planning, coordination and authorization processes?

Coverage and Authorization of Services (438.210)

2. Are emergency back-up plans created for all enrollee's? If not, how is the need for an emergency back-up plan determined? How is the emergency back-up plan shared with all appropriate parties?

MCO Providers and Contractors (as appropriate)

Interviewing providers and contractors requires additional time and resources. However, it is an opportunity to obtain further information about MCO performance from those health care and LTSS professionals and institutions that often serve as the first point of contact for Medicaid members and health care providers. Because of this, provider and contractor interviews should be considered as an optional component of this protocol - to be considered whenever there is a strong need for additional information and when time and resources permit. The interview participants should be selected from the provider network and should offer representative view of the breadth of the MCO's primary care, specialist, LTSS and institutional providers. These persons can often clarify issues pertaining to communication, traversing the system, assuring enrollee rights, and delivery of care and services to the enrolled population.

There are several ways to conduct the interview. The interview can be arranged with a group of individual health care practitioners, a group of institution representatives, and a group of LTSS providers. It can be coordinated as one interview for each group or as a combined group. Geographic location of providers should be considered, and conference calls are a viable option for conducting an interview of this type, and often preferred by providers as only a brief interruption in their daily activities. In order for this interview to be effective, reviewers should emphasize that this is an opportunity to provide insight on the MCO's performance and not an evaluation of the care and services offered to Medicaid enrollees.