

TAC Monitoring Tool

- LME Monitoring Tool Review
- February/March Tool Review Purpose/Results
- Adjustments Made to What is Monitored and to TAC Tool

Functions

There are six (6) primary functions that correspond to administrative units common to many LMEs:

- 1. Governance/Administration,**
- 2. Provider Relations/Development,**
- 3. Service Management,**
- 4. Quality Management,**
- 5. Customer Service/Consumer Affairs**
- 6. Business Management/Information**

PROVIDER DEVELOPMENT

The service philosophy of the North Carolina State Plan 2005: Blueprint for Change includes expectations that the LME will recruit providers; identify generic community services and supports; implement and maintain the endorsement process; provide training, technical assistance and communication appropriate to maintaining a provider network; implement a social marketing plan; provide arbitration/ resolution of provider complaints/grievances; provide care coordination; and ensure collaboration among providers.

The Provider Relations aptitude of the LME is integral in the person-centered philosophy and “no wrong door” concept, as providers are the backbone for the service delivery system.

PROVIDER DEVELOPMENT

Provider Endorsement and Monitoring	Technical Assistance	Community Development Plan	Provider Contracting	Arbitration/Resolution of Provider Complaints and Grievances
Perform Provider Endorsement activities in an accurate and timely manner, consistent with DMA and DMH/DD/SAS Provider Endorsement Policies.	Provide technical assistance to providers on LME specific processes/ policies regarding operations and DHHS policies and communications. Provide technical assistance on EBP.	Ongoing recruitment and maintenance of the provider community based on local needs assessment.	Provider contract administration in accordance with standardized DHHS provider contract.	The LME shall establish written procedures for dispute resolution regarding LME decisions with a contractor, former contractor, or person asserting the claims described in G.S. 122C-151.4, and decisions may be appealed to the Area Authority Appeals Panel.
SB163 Provider Monitoring - ensure the quality of services and supports delivered by the providers operating in its catchment area for compliance with the law, not to supersede or duplicate regulatory authority or functions of agencies of the Department.	Develop and maintain a current Provider Manual to inform providers regarding LME and DHHS processes, procedures and policies.	Conduct annual gap analysis to identify additional capacity/types of providers needed – includes identifying unserved/underserved consumers	Review results of State audits.	Review provider complaints and grievance process per the DMH policy.
Monitor first responder capability semi-annually. Monitor use by Providers of EBP.	Follow up with providers to improve crisis plans of consumers who receive emergency/Mobile Crisis service while assigned to a clinical home provider.	Work with providers to ensure adequate community emergency response capacity.	Sub recipient monitoring.	
Monitor providers' progress on achieving national accreditation.	Provide targeted quality review of identified providers PCP for quality improvement	Work with Provider Community to ensure expansion of EBPs.		

Provider Relations Monitoring Instrument

LME Reviewed: _____

Date(s) Reviewed: _____

LME Liaison: _____

Reviewer(s): _____

Instruction to reviewer: Items in bold note priority indicators and thus rating points are higher.

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME conducts an annual assessment of community need and provider capacity. [Attachment I, 5.1]	Current year and past year community assessment and development plan Minutes of LME staff / Board/ CFAC meetings Minutes from community needs assessment steering committee meetings NC TOPPS data Claims data U.S. Census data	The LME has a written community needs assessment and development plan dated within the past year. Assessment includes: •Input from individuals and family members •Input from other community stakeholders •Review CAP/MRDD waiting list to determine patterns of need •Comparison of proportion of persons served to state norms by specific population (mental health, developmental disabilities, substance abuse), age, & service type. •Provider capacity and willingness to participate in community emergency response efforts •Cultural and linguistic capacity LME updates community capacity assessment on a biannual basis. LME expenditures of State funds for prior year shortfalls are addressed in development plan.	LMEs should employ a variety of tools to solicit information from individuals and families including surveys and focus groups. The needs assessment should include elements relevant to all of the priority populations as well as movement toward evidence based practices. The needs assessment should take into account the findings from the last needs assessment. The needs assessment should address the needs of ethnic and cultural minorities. Compare current community assessment & development plan with prior community needs assessments. The plan of action resulting from the needs assessment should prioritize action items and describe levels of effort in measurable goals. Community needs assessments typically include the following stages: 1.Create a diverse stakeholder group (steering committee) to lead assessment activities 2.Define issues/problems to address 3.Collect information from extant and available resources 4.Gather new information in targeted areas 5.Analyze information and define gaps 6.Create plan of action with measurable goals 7.Share assessment information and plans with broader community	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME uses the annual community needs assessment to determine the ability of current providers to meet the needs of clients likely to seek services. [Attachment I, 5.1]	LME community assessment and development action plan/ work plan Provider recruitment materials Technical assistance requests Numbers of providers recruited in specific priority areas Provider monitoring & endorsement reports (summaries) Provider surveys Provider meeting minutes Bulletins	The LME community needs assessment includes an analysis of the match between needs identified and the availability and capacity of current providers to meet the needs by population. The action plan addresses any shortfalls in the availability of crisis response identified in the community needs assessment.	The community needs assessment should form the basis for provider recruitment, technical assistance and other related provider relations initiatives. The assessment should also link the current assessment to findings from previous assessments. The assessment should identify poorly performing portions of the provider network and specific plans for improvement.	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME provides updates to the LME Board and CFAC on a quarterly basis regarding progress toward meeting the community's need. [Attachment I, 5.1]	Minutes of LME Board and CFAC meetings Interviews with LME Board members and CFAC members	LME demonstrates that regular and periodic presentations were made regarding the community needs assessment and progress toward meeting the need. LME demonstrates that input and advice from Board and CFAC members influenced direction.	Based on the community needs assessment, LME staff should prepare status reports for Board and CFAC regarding provider recruitment, technical assistance, and other initiatives suggested by the community needs assessment. This should also include any identified need of racial and cultural minorities. The Board and CFAC should be more than simply recipients of the information but also should contribute to the priorities.	(2)	(1)		
The LME maintains the minimum number of competent/quality providers for every service to ensure choice. [Attachment I, 5.2]	Policy & procedure Interviews with individuals and families regarding choice of providers for each service recommended or requested Community assessment and development plan Outreach and marketing information regarding services informs public of availability of choice of provider	Individuals have a choice of at least 2 IPRS providers per service type for each geographic area except for those services where 2 providers are not feasible (e.g., insufficient demand to support two providers, cost of service, availability of a regional provider, etc.). LME identifies areas where additional providers are needed and has developed a plan to expand the provider network and/or has reasonable justification for fewer than 2 providers.	The community needs assessment should include a review of the provider network to determine whether individuals are afforded choice of providers for the full range of services. The LME canvasses individuals to determine whether they had choice of provider.	(4)	(2)		

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME carries out timely endorsements and enforces endorsement requirements for applicable services. [Attachment I, 5.4]</p>	<p>Policy & procedures LME records of providers and services endorsed in past year LME records of providers for whom the LME did not grant endorsement, including examples of providers denied endorsement for failing to provide timely data Interviews with LME staff that engage in endorsement and monitoring activities LME records of providers with Plans of Correction due to failure to meet data requirements LME endorsement policy & procedures and related documents, noting time frames, local reconsiderations of withdrawals, appeals and outcomes.</p>	<p>The proportion of providers endorsed during the past 12 months wherein the deadlines in policy for initial review, onsite review and final decision are met. LME imposes corrective actions and removes endorsement from providers that fail to provide required data to LME as per timelines or fail to meet the basic quality criteria identified in the contract. Proportion of endorsements reviewed by the Division that include all necessary information regarding the potential provider. LME uses standard MOA provided by DHHS for endorsement as a Medicaid provider. Withdrawals of endorsement are documented and tracked.</p>	<p>Prior to on-site review, determine through paid Medicaid claims data which providers in the LME catchment area are billing Medicaid for endorsed services. Select the 5% sampling of files from this group. LME records should indicate a thorough review of providers seeking endorsement. LME monitoring should track provider compliance with data requirements and track and trend areas of non compliance. LME records should indicate and track reasons for endorsement denials.</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME maintains a provider manual. [Attachment 1, 5.3/5.6]	LME provider manual: hard copy, online. LME's distribution portals for updates to provider manual.	Provider manual contains current instruction on LME and DHHS process, procedures, timelines, State and Federal guidelines and requirements including: <ul style="list-style-type: none"> •consumer rights •service definitions •confidentiality •HIPAA •billing •documentation LME demonstrates that the manual has been shared with current and new providers. Information and references in the manual are accurate and within State and Federal guidelines.	The provider manual should include how the LME functions, Memos of Agreement with other community organizations, regularly scheduled meetings, joint care planning, needs assessment, quality improvement strategies, etc. The provider manual should also include sections that are standardized statewide including processes such as incident reporting, data collection submissions, appeals and complaints.	(2)	(1)	(0)	
The LME conducts technical assistance and training. [Attachment 1, 5.3/5.6]	LME-Provider meeting minutes Provider records note requests and/or receipt of training and technical assistance Curricula and credentials of trainers Interviews with providers Interviews with LME staff regarding providers with a history of inadequate progress or QI Brochures	LME training and technical assistance includes: <ul style="list-style-type: none"> •LME policies, procedures, & requirements; •DHHS policies/ communications •Developing & implementing crisis plans •Improving QI activities •Navigating the MHDDSAS system •Understanding State DMHDDSAS requirements or LME protocols •Evidence based practices implementation LME technical assistance and training has been provided in areas covered by DHHS-LME contract.	Training to provider network should include information about data submission (e.g., NCTOPPS), billing, incident investigations, complaints, First Responder capability, etc. Meetings with provider network should include training at least quarterly. LMEs are not required to offer training for normal operating procedures nor training if a provider has a history of not being able to assimilate previous technical assistance offered by the LME. LMEs may arrange for provision of technical assistance through third parties.	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME evaluates and monitors provider quality on a continuing basis. [Attachment I, 5.5]</p>	<p>Policy and procedures Staff credentials LME documentation of monitoring providers according to confidence levels Sample of the LME provider monitoring reviews Sample of Plans of Correction and LME tracking and follow up Incident and complaint reports and LME tracking and trending DD case manager or clinical home reports Mystery shopper results</p>	<p>The LME monitors & engages providers based on a Monitoring Frequency tool that tracks progress toward accreditation; community emergency response capacity, compliance with data submission; incident reporting; consumer rights; quality assurance activities LME monitors first responder capabilities semi-annually The proportion of providers that are monitored based on the confidence assessment derived from the Monitoring Frequency Tool. Provider plans of correction are monitored by the LME for timely implementation as per LME policies and procedures. LME monitors plans of correction requested by DMA or DMHDDSAS as per auditing entity. LME conducts ad hoc monitoring when in receipt of information of serious problems at a provider (e.g., based on complaints, incidents, case manager reports, etc.).</p>	<p>Ensure all policies, procedures & timeframes are in compliance with State policy and procedure. The LME should be using a standardized state monitoring tool. The LME should use the current State checklists without additions or deletions. When reviewing files, select a 5% sampling from all providers regardless of payment source. The LME can develop local additions to the tool to identify, promote and assess for priority best practices. Prior to the conduct of monitoring for a specific provider, all relevant information should be reviewed including serious incident data. Staff conducting the provider monitoring have the credentials necessary to make appropriate judgments. The LME should ensure that there is documentation regarding remediation of individual and provider monitoring findings. The LME should have a protocol whereby ad hoc monitoring takes place based on adverse information generated from case managers, incident data, complaint data, etc. LMEs should comply with DHHS policies and statutes for monitoring and should not duplicate regulatory authority or functions provided by another entity.</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME monitors the timeliness and accuracy of provider data submission requirements. [Attachment I, 5.5]	Records of provider data submission	The proportion of providers submitting timely and accurate data submissions. Description of process used to review and validate data. Proportion of NCTOPPS surveys submitted compared to total number of clients served	The LME should use provider data as one element of the local community needs assessment.	(4)	(2)	(0)	
The LME resolves provider complaints.	Records of complaints regarding providers, records of complaint resolution	The proportion of provider complaints reviewed that indicate timely resolution Provider complaints are analyzed and trends are shared with the LME and CFAC Board	The LME should not only respond to provider complaints but should also aggregate the complaint information to determine whether there are any trends Complaint data should be reviewed prior to the conduct of monitoring with specific providers	(2)	(1)	(0)	

SERVICE MANAGEMENT

Per House Bill 2077-122C-115.4 (d) Functions of Local Management Entities, local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources to include: (b) (1) access for all citizens to the core services described in G.S. 122C-2, (5) Care coordination and (6) Community Collaboration.

Providing access for all citizens to the core services described in GS 122C-2 is included under Service Management. In particular, this shall include the implementation of a 24 hour a day, seven day a week screening, triage and referral process and a uniform portal of entry into care.

Care Coordination is considered a Service Management Function with the support of Quality Management and Provider Relations and Development Management (monitoring & reviewing consumer charts). This function includes the direct monitoring of the effectiveness of person centered plans. It also includes the initiation of, and participation in, the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers and review of consumer charts.

Service management also includes: utilization management, utilization review, and determination of the appropriate level and intensity of services, including the review of the person centered plans and authorization of state funded services; concurrent reviews of person centered plans for all consumers who receive Medicaid funded services; authorization of the utilization of State psychiatric hospitals and other State Facilities; authorization of eligibility determination for recipients under the CAP-MR/DD waiver.

SERVICE MANAGEMENT

Care Coordination	Concurrent Review of Medicaid-covered PCPs	UR/UM State Dollars	Community Collaboration
Ensure continuity of care of consumers who are discharged from state institutions, hospitals, or other emergency services <i>for those consumers who do not have a clinical home provider agency, until a provider agency is chosen.</i>	Review of <u>10%</u> PCPs and Plans of Care for Medicaid services for appropriate components of plan – quality of plan development, evidence of person centeredness, use of EBPs, natural and community supports, adequacy of crisis plan.	Conduct UR for all services provided to consumers in catchment areas receiving State (IPRS) funding in accordance with UR timeframes as spelled out in the service definitions. Perform UR functions in time-efficient manner, with a benchmark of no more than 15 minutes for reauthorization of routine services and no more than 30 minutes for authorization of high-end, specialized services.	Develop and maintain effective relationship with Local and State governmental officials. Develop relationships through MOAs with other key agencies: Schools, Juvenile and Adult Justice systems, local hospitals and primary care providers, DSS, Sheriff, courts, etc.
Act as a liaison to providers and the authorizing agent as necessary, to effect changes in PCP for high cost/high risk consumers and ensure the use, as appropriate, of Evidence-Based Practices (EBP).		Review of 25% PCPs for non-Medicaid funded services for appropriate components of plan – quality of plan development, evidence of person centeredness, use of EBPs, natural and community supports, adequacy of crisis plan.	Develop a strong and seamless network of supports and services.
Ensure services and supports (including EBPs), in coordination with clinical home provider agency, for high risk consumers with primary care physicians are available.	Provider Sampling: Choice based upon LME experience with Provider Network.		Initiate and complete an annual assessment of community strengths and needs in regard to natural services and supports within the community at large and in light of EBPs.
Ensure provider Participation on Child & Family Teams.			Develop social marketing plan. Implement public awareness campaigns re prevention and education including use of EBPs.
Participate in Child and Family Team meetings as needed for high risk, high cost consumers and ensure that EBPs are being used, where appropriate.		Authorize utilization of State psychiatric hospitals and ADATC resources	Participate in development of community emergency response plans.
Participate in person centered planning and case reviews as needed for high risk, high cost consumers ensuring a focus on EBPs.		Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.	Provide leadership and active participation in local Collaborative efforts that bring together public agencies and groups to coordinate and improve services to NC residents.

Service Management Monitoring Instrument

LME Reviewed: _____

Date(s) Reviewed: _____

LME Liaison: _____

Reviewer(s): _____

Instruction to reviewer: Items in bold note priority indicators and thus rating points are higher.

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME publishes a consumer benefit plan for state-funded services ^[1] [7.1.1 DHHS-LME Contract Attachment I, Scope of Work]	Service approval forms Minutes of the LME Board of Directors Minutes of the CFAC Published benefit plan on LME website General distribution handouts for consumers, providers, etc.	The benefit plan for state funded services is made available to providers, consumers, members of the LME Board and members of the CFAC The benefit plan includes an array of services for each age and disability group The benefit plan includes guidelines for parameters and intensity of each service The benefit plan is reviewed by the LME Board and the CFAC The benefit plan is revised periodically to reflect the findings of the community needs assessment Review of a sample of service approval forms indicates that an array of services are authorized per age and disability group Review of a sample of service approval forms indicates that services are authorized for the appropriate parameters and at intensity levels as defined by the benefit plan	The LME publishes a consumer benefit plan that reflects the needs of people within the LME's jurisdiction and across disabilities and is consistent with available local resources. The consumer benefit plan should be available in multiple formats including available for download on the LME website. The content of the plan should take into consideration the community needs assessment as well as recommendations from the board and CFAC. The plan should be updated periodically and periodic reviews should be conducted to ensure that people are receiving services of the types and quantity outlined in the plan.	(2)	(1)	(0)	

[1] Going forward, the state will publish a minimum service plan/specification of core services – each LME will need to publish its own benefit plan modifying the state plan by (a) services funded with local or other discretionary funds; and (b) limitation in state resources

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME has 24/7/365 crisis response for its catchment area and implements the DHHS approved LME crisis services plan [7.1.2 DHHS-LME Contract Attachment I, Scope of Work, Attachment II Performance Expectation, Timely Access to Care Indicator]</p>	<p>LME approved crisis plan Interviews with LME staff Interviews with first responders Qualifications of LME staff RFPs MOAs Timely Emergent Care Progress Indicator</p>	<p>Benchmarks identified in the LME crisis plan have been met LME staff are familiar with the provisions of the crisis plan Providers and first responders are familiar with the provisions of the crisis plan The LME has staff/contractors with the professional experience (age-disability specific) and qualifications to implement crisis services. Reduction in institutional admissions and bed day utilization The LME has MOAs with relevant local entities including law enforcement and general hospitals The LME has a 24/7/365 crisis service Variance (+ or -) from assigned bed day allocations Timely emergent care indicator aligns with state average</p>	<p>The implementation of the LME's approved crisis plan should result in noticeable outcomes including the presence of individual crisis plans as part of each consumers person centered plan, the authorization of crisis services in a timely fashion, the reduction in admission to short-term inpatient/restrictive settings precipitated by crises, and the increased use of ADATCS especially for acute services The crisis services portion of the LME provider manual should provide procedures related to: (122C-117(a)(14))</p> <ul style="list-style-type: none"> •Availability of telephone and in person response •Contact initiated w/in one hour of notification •Service designed for prevention, intervention, resolution •Intervention completed in least restrictive setting 	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME has a process for the review of person-centered plans [7.1.3 DHHS_LME Contract Attachment I, Scope of Work]	LME review protocol for person centered plans Interviews with LME staff Person centered plans reviewed by disability, funding source and service type Proportion of Medicaid funded PCPs available for review compared to total number of Medicaid funded PCPs Guidance regarding PCPs included in LME provider manual Training and technical assistance log	Proportion of PCPs reviewed by disability for state funded services Proportion of available PCPs reviewed by disability for Medicaid funded services Problems identified in PCP review are communicated to the planning team and the case manager and appropriate changes are documented The number of TA, training and other initiatives based on a review of provider trends growing out of individual plan reviews Evidence that the LME has provided or assured availability of training/technical assistance to LME providers LME criteria for PCP reviews include standards outlined in the PCP Instruction Manual LME reviews PCPs received from Medicaid providers to assess whether the plan is in compliance with DHHS policies and procedures	Individual person centered plans are reviewed by the LME to assess the quality of the planning process. The review should include crisis strategies, health and safety issues, consumer choice of provider, appropriate diagnosis, linkage of diagnosis/assessment to services, and agreement and participation of consumer/family. Goals/interventions in the plan build on individual and family strengths and should reflect the use of evidence based and best practices Individuals and families participate in developing person centered plans and identify what is important to them. LME has staff/contractors with the professional experience (age-disability specific) and qualifications to carry out review of person centered plans. The LME PCP review, to be the most efficient should be based on a sample that is weighted for those most at risk	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME makes service authorization decisions within required timelines [7.1.4 DHHS-LME Contract Attachment I, Scope of Work]</p>	<p>Requests for service authorizations Authorization records Interview with LME staff and providers LME UM/UR criteria and clinical protocols for the service authorizations and re-authorizations Use PCP's from 7.1.3 – for routine and urgent use a random sample of authorizations within each disability group</p>	<p>The proportion of routine service requests authorized within 14 days. The proportion of urgent service requests authorized within 24 hours The proportion of service authorizations and reauthorizations that follow the LME UM/UR decision making criteria Proportion of service authorizations that correspond to duration and intensity guidelines in the benefit plan</p>	<p>LME authorizes state-funded services based on a properly completed PCP and in accordance with the LME's benefit plan for the consumer's target population LME has staff/contractors with the professional experience (age-disability specific) and qualifications to carry out service authorization within required time lines. The LME links all service authorizations to claims processed. Decisions regarding service authorization and reauthorization should be based on valid and reliable clinical criteria spelled out in the LME benefit plan and clinical protocols. The LME should also carry out periodic reviews to ensure that the decision making protocols are being followed</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME notifies consumers of rights and appeals regarding LME service authorization decisions [7.1.5 DHHS-LME Contract Attachment I]</p>	<p>LME protocol for informing consumers of their rights of appeal and documentation of the communication of such information Records of authorizations denied Records of appeals filed Interviews with LME staff Interviews with consumers Interviews with providers</p>	<p>Proportion of recipients who received information about their right to appeal and the process for an appeal of an LME service authorization decision at the time they received a denial or notice of reduction in services Rights are communicated to recipients in accessible formats</p>	<p>LME ensures that recipients are informed of their rights, protections and responsibilities in a manner that is understandable to the person and/or their parent or legal guardian. The LME should have the capacity to provide assistance to consumers and families wishing to file an appeal</p>	(4)	(2)	(0)	
<p>The LME uses licensed staff to conduct Audit and Post-payment review [7.1.6, DHHS-LME Contract, Attachment I, Scope of Work]</p>	<p>Credentials and qualifications of Audit and Post-Payment staff Sample of PPRs LME reports submitted to DMA</p>	<p>Staff (or LME consultants) conducting audit and post payment reviews have appropriate licenses and qualifications The LME has arrived at a specific number or % of post-payment reviews to accomplish on an annual or quarterly basis</p>	<p>LME conducts post payment reviews of Medicaid and non-Medicaid funded services for clinical appropriateness, regulatory compliance, quality and quantity Staff carrying out post payment reviews should be licensed clinicians LME should have licensed clinicians and administrative staff available to participate in appeals process, development of future tools and processes to address enhanced services LME should report its specific findings to the DMA Program Integrity Unit and should use standard DHHS documents and protocols</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME manages and prioritizes CAP-MR/DD Waiver services [7.1.7 DHHS-LME Contract, Attachment I, Scope of Work]</p>	<p>Policies and procedures regarding CAP-MR DD waiver priorities Materials available to families and consumers regarding criteria for the waiver Records of individuals denied admission to the waiver and steps taken to direct them to other services through referrals, state funded services and other information LME waiting list for CAP/MRDD services LME policy for informing case managers when slots become available Records of individuals admitted to the waiver over the past year Minutes of Board and CFAC meeting – input regarding prioritization criteria</p>	<p>Proportion of individuals admitted to the waiver who met the waiver priority criteria. Proportion of individuals denied a waiver slot who did not meet waiver priority criteria LME regularly shares prioritization information with Board and CFAC. Proportion of people who did not gain access to the waiver who received information, referrals and/or other services through the LME People who come off of the waiting list meet the LME priority criteria LME notifies case managers of most acutely in-need consumers when additional consumers can be added to the CAP-MR/DD waiver to process eligibility determination requests</p>	<p>The prioritization scheme adopted by the LME takes into account such factors as the age and/or disability of the parents, recent death of caregiver, inability of caregiver to meet the needs of the individual, involvement in the criminal justice system, deterioration in level of functioning, etc. LME staff have the credentials and are trained to implement the priority scheme in a consistent and equitable fashion</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME coordinates the care for high cost/high risk consumers and consumers without a clinical home [7.2.1 DHHS-LME Contract, Attachment I, Scope of Work]</p>	<p>Plan for identifying high risk/high cost consumer and those without a clinical home Records of high cost/high risk consumers and their PCPs and consumers without a clinical home Interviews with care coordinators/case managers Crisis plans for high cost/high risk consumers Hospitalizations for high cost/high risk consumers and those without a clinical home Protocol for care coordination of high risk/high cost consumers and those without a clinical home</p>	<p>The LME identifies high risk/high cost consumers and individuals without a clinical home based on their plan and/or have addressed issues in implementation Number of high risk/high cost consumers admitted to inpatient settings during the past year Number of high risk/high cost consumers for whom costs increased during the past year Number of crisis plans that have been updated as the individuals circumstances changed The LME provides care coordination to people without a clinical home coming out of hospitals, state facilities or emergency services within 5 day of discharge</p>	<p>Care coordinators for high cost/high risk consumers and those without a clinical home should: •Assist and advocate with providers so that consumers receive needed services •Assist providers with complex cases •Review termination summaries from providers to assess for appropriateness to ensure that providers are not prematurely terminating consumers. •Monitor the initiation of new services by contacting providers promptly after referrals are made to ensure that services have been initiated. LME has designated staff to participate in annual Plan of Care meetings for consumers from their catchment area residing in a Developmental Center that are appropriate for community placement</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME has active collaborative relationships with other human service agencies</p>	<p>MOUs with community generic, civic and social services organizations List of referral agencies Minutes of LME Board Minutes of CFAC Provider manual Interviews with LME staff and community agencies The community emergency disaster response document</p>	<p>The LME has developed MOUs and other formal and informal relationships with generic, civic, and community social service agencies including employment and housing agencies Community agencies are invited and participate in LME Board and CFAC meetings The provider manual includes information about generic, civic and community social services agencies The LME maintains a list of generic, civic and community social services agencies The LME is a participant in the community emergency disaster response plan</p>	<p>In order to ensure that clients of the LME can take advantage of a range of supports in addition to those offered through the LME, it is important that the LME reaches out to other agencies to explore collaborative relationships, to offer support and technical assistance, and to explain the services of the LME and the nature of its clientele LME collaborative relationships with other agencies can maximize the scope and reach of LME services and enrich the supports available to LME consumers through joint projects and initiatives</p>	(4)	(2)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME encourages the use of natural and community supports [Attachment I, 7.3.3]	PCP review protocol Provider manual Memoranda of Understanding with generic community agencies Interviews with LME staff Interviews with care coordinators and case managers Minutes of the CFAC Budget for family support	The LME has collaborative relationships with other generic and human services agencies including local education, justice, health and social services. The PCP review protocol includes an assessment of the presence of natural and community supports The LME provider manual addresses the availability of community generic supports The CFAC makes recommendations regarding ways to increase the use of natural and community supports	There are a variety of ways that LMEs can increase the use of natural and community supports including active outreach to generic, civic, recreational and other social services agencies; working with families and consumers to introduce them to community supports; ensuring that care coordinators/case managers emphasize such supports; and involving the CFAC to help with outreach and make recommendations	(2)	(1)	(0)	
The LME has a full-time System of Care coordinator [7.4.1 DHHS-LME Contract Attachment I]	LME staff roster Qualifications of System of Care Coordinator	LME maintains a full-time staff position to coordinate System of Care initiatives. The System of Care Coordinator has the requisite experience and credentials to carry out the job	The System of Care coordinator is responsible for supporting the LME's Community Collaborative	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME has designated staff to coordinate deaf services, school-based child and family teams, and development of housing opportunities (if applicable) [DHHS-LME Contract Attachment I, 7.2.3 & 7.3.5 & 7.4.2]	LME staff roster, TOO, and roles and responsibilities Qualifications of staff assigned to coordinate deaf services, school-based child and family teams, and development of housing opportunities	There is a designated coordinator for deaf services, school-based child and family teams, and development of housing opportunities (if applicable). The designated staff have the requisite experience and credentials to carry out the job		(2)	(1)	(0)	
The LME makes quarterly reports to the LME Board on service utilization patterns of state funded services [DHHS-LME Contract Attachment I, 1.2 & 8.4]	Minutes of Board meetings. LME annual Business Plan LME Community Needs Assessment Service utilization reports Quarterly expenditure reports	The Board receives quarterly reports from the LME regarding service utilization patterns The report compares service utilization/expenditures to available dollars The Board makes recommendations regarding possible ways to reduce high cost services and to reduce inpatient use	The purpose of quarterly reports on utilization patterns is to ensure that the use of high cost services is minimized through the implementation of prevention and crisis strategies, to identify potential problems and trends, to examine necessary changes, and to track whether the LME is on track to expend the state allocation)	(2)	(1)	(0)	

QUALITY MANAGEMENT

House Bill 2077-122C-115.4. Functions of local Management Entities (b) (4) Quality Management.

This function includes the monitoring of the effectiveness of person centered plans. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers and review of consumer charts. In collaboration with the care coordination function of service management, quality management includes participation in the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner.

QUALITY MANAGEMENT

Data Analysis/ Reports	Quality Improvement	Quality Assurance
Consumer Outcomes: (NC TOPPS/ DD COI).	Develop surveys and studies including EBP and Promising Practices. Minimum of Three QI Studies (annually) of LME operations and functions.	Audit Coordination and compliance of 122C-Licensed Providers / Endorsed Service Providers.
Service Utilization Patterns: -IPRS -LME Hospital Utilization data (Including SOS BDU Reports) -Crisis Utilization.	Review Community Provider Network QI Studies.	Incident Reviews and Reporting.
DMHDDSAS Compliance Reports.	Compare population census disability prevalence data w/ LME consumer Penetration data.	Review complaints on provision of services.
Trend Analysis: -Consumer -complaints -client rights -outcomes -Provider -audits -performance -satisfaction -Evidence-Based/Promising Practices -Internal LME Operations -Management of State dollars and State facility usage - Continuity of Care from State Operated Facilities (SOF). - LME Care Management effectiveness of high-risk consumers. -Access STR standards -Other Stakeholders -Community Agency complaints.	Process Improvements: - Develop internal processes to monitor and evaluate the level of quality obtained by all programs and services.	Technical Assistance on Quality issues including implementation of EBPs.
Ensure EBP outcomes.	Risk Management assessment: Using trend analysis data assess indicators that serve as potential risk to LME.	

Quality Management Monitoring Instrument

LME Reviewed: _____

Date(s) Reviewed: _____

LME Liaison: _____

Reviewer(s): _____

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
<p>The LME identifies and remediates problems in a timely fashion (Attachment I, 9.1)</p>	<p>Level II & III incident reports tracked by provider, by incident type, by staff involved, by individual(s), by resolution Local LME Incident Trend reports Incident reports and outcome data from other investigating entities (e.g., DSS, DHSR) Provider complaint log LME tracking & trending of provider complaints Minutes of LME management review of incident and complaint data trends Documentation of remediation based on trend data</p>	<p>Number of incidents of substantiated abuse/neglect compared to state average (or designated range or target) Number of preventable deaths (Level III incidents) compared to state average (or designated range or target) Aggregate and trend data is periodically reviewed and covers the following: <ul style="list-style-type: none"> •Level I, II, and III incidents •Consumer outcomes and perception data •Utilization patterns (providers, STR system, crisis) •Treated prevalence •Complaints, grievances •Provider compliance •Internal LME reports/data •State facility usage </p>	<p>The LME analyzes Level II and III incidents reported by providers to determine trends and take action to make system improvements as defined by 10A NCAC 27G.0600 The LME analyzes Level I, II and III incidents providers to determine trends and take action to make system improvements. The LME evaluates providers with low levels of certain types of incidents to ensure that there is an atmosphere that supports reporting exists. The LME uses complaint data on providers to determine emerging trends and to identify providers that should receive additional monitoring The LME uses data at its disposal to determine whether the agency's outreach is successful, consumer outcomes are being achieved, state facility use is minimized, and that other indices of potential crises are minimized The LME can show that it has used data to remediate immediate jeopardy as well as to forestall emerging problems or crises</p>	(4)	(2)	(0)	
<p>The LME produces and reviews regular management reports (Attachment I, 9.2)</p>	<p>Reports regularly reviewed by management staff including: <ul style="list-style-type: none"> •Financial status reports •Staffing, turnover and retention reports •Consumer outcome information •Incident trend data •Other data-based reports • Minutes of LME management meetings Interviews with management staff</p>	<p>Management meeting minutes note review of aggregate and trend data across the system, local, and by population and strategies implemented to address immediate problems as well as to forestall emerging/potential problems</p>	<p>LME prepares regular management reports on key operations for review by management team. These management reports should form the basis for managerial decisions regarding provider relations, resource allocation, technical assistance, monitoring and oversight, provider development and service utilization</p>	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME analyzes data and uses results for planning, decision making and improvement (Attachment I, 9.4)	Annual Quality Improvement report Quarterly reports evaluating Level II and Level III incidents Interviews with management staff	LME submits an annual Quality Improvement report describing how it has used its quality improvement process to address service delivery system issues in at least one of the following areas: building service capacity; ensuring quality of care for high risk/high cost consumers; ensuring continuity of care and/or ensuring use of evidence-based practices. The LME's Quality Improvement report should include: •Basis for choosing the targeted area for improvement (e.g. data analyzed) •Strategies developed to address identified areas •Actions taken •Evaluation of results to date •Recommendations & time lines for next steps	The LME uses its quality improvement process to improve the service delivery system. The LME uses performance data to improve the quality of the system of services	(4)	(2)	(0)	
The LME has an active Quality Improvement committee (Attachment I, 9.4)	QI Committee minutes Management meeting Interviews with Quality Improvement Committee members	Minutes of Quality Improvement Committee show that the majority of members are present for meetings, data is reviewed, and recommendations made. LME QI reports: •identify systemic issues, •prioritize with input from consumers and families, and implement interventions to improve services.	The LME Quality Improvement Committee meets frequently; members are knowledgeable about LME operations and their role in providing guidance, and makes recommendations for addressing issues.	(2)	(1)	(0)	

DHHS Requirement	Suggested Source(s) of Information	Evidence of Compliance	Guidance	Rating			Comments/ Corrections Needed including Technical Assistance
				Met/ Exceed	Partially Met	Not Met	
The LME reports on QI activities to the LME Board and CFAC quarterly and to DMHDDSAS annually (Attachment I, 1.2 & 9.4)	CFAC and LME Board minutes Interviews with CFAC and LME Board members	Trend reports are reviewed by CFAC and LME Board members. CFAC members and LME Board members sign off on quarterly QI reports DMHDDSA records indicate timely submission of QI reports.	The LME submits required data in a timely fashion. The LME tracks and trends data on local system performance Report on QI activities to Board and CFAC quarterly and to DHHS annually.	(2)	(1)	(0)	

LME Monitoring Tool Review Purpose/Results

- CSPR and Performance Contract linked
- Eight LMEs reviewed in February/March
- Results:
 - Tenuous link between CSPR and Perf Cont
 - LMEs, in general, following Perf Cont stds
 - Excellent Feedback on appropriate bases for CSPR
 - Adjustments made to CSPR bases

LME Tool Adjustments

- LME Team is reviewing the LME Monitoring Tool to:
 - Make it current with new Perf Cont
 - Consolidate repetitive elements
 - Adjust and make more accurate Sources of Information
 - Determine definitive objectives for DHHS Requirements/Evidence of Compliance/Guidance elements

Adjustments Made to What is Monitored and to TAC Tool

LME Monitoring Tools

For more information:

LME Team

919.715.1294