Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.28					
6.28.1	The MCO shall have a referral system for MCO members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The MCO shall provide the coordination necessary for referral of MCO members to specialty providers. The MCO shall assist the member in determining the need for services outside the MCO network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.	Met The P/P 156.701 Coordination with Other Services addresses the process used by the Plan's Integrated Care Management to "proactively coordinate the provision of services to Members who need specialized behavioral health services (including inpatient and/or outpatient behavioral health care), services from non-participating Practitioners/Providers, other healthcare services and non-healthcare services with the services covered by AmeriHealth Caritas Louisiana to facilitate delivery of holistic care and avoid duplication of services. AmeriHealth Caritas Louisiana's service coordination includes, but is not limited to, identification and referral to available community resources, referral to behavioral health care providers, and coordination with other external services.	156.701 Coordination with Other Services	"Procedure" Section	Pages 1- 4
6.28.2	The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:	Met As an incumbent plan, AmeriHealth Caritas has met this requirement by submitting the materials for DHH approval.	Member Handbook Provider Handbook		
6.28.2.1	When a referral from the member's PCP is and is not required (See Section §8.5.1.6 Exceptions to Service Authorization and/or Referral Requirements);	Met The Member Handbook (p.30) lists services that do not require a referral. The document does not specifically list when a referral is required but it states that is the member is "not sure if you need a referral from your PCP for a service, ask your PCP or call Member Services". The Provider Handbook states that "referrals are not required for specialty services".	Member Handbook Provider Handbook	Getting Care - Self-Referrals Referrals	Page 30 Page 37
6.28.2.2	Process for member referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the member;	Met The P/P UM.904L: Authorization for OON Providers (p.2) states "Services Unavailable from Participating Specialist/Provider: Medically Necessary out-of-network services if the requested services are not available within the ACLA network or if participating specialists/providers do not have the necessary expertise/training to provide the services. If coverage is approved, one evaluation visit and one follow-up visit are initially approved unless otherwise approved by the Medical Director or Physician Reviewer. Requests for services beyond the initial approval are reviewed for Medical Necessity."	UM.904L: Authorization for OON Providers	Policy Section	Page 2 #2
6.28.2.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Met The Member Handbook (p.30) lists services that do not require a referral. The document does not specifically list when a referral is required but it states that is the member is "not sure if you need a referral from your PCP for a service, ask your PCP or call Member Services. The Provider Handbook states that "referrals are not required for specialty services".	(With DHH approval, ACLA does not require members to receive a written PCP referral to see a specialist.)	N/A	

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
		The UM Program Description states that the plan does not require a written referral for specialist claim payments, a provider may enter a standing referral with a specialist as in the Policy.			
6.28.2.4	Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;	Met The Member Handbook (p.30) lists services that do not require a referral. The document does not specifically list when a referral is required but it states that is the member is "not sure if you need a referral from your PCP for a service, ask your PCP or call Member Services. The Provider Handbook states that "referrals are not required for specialty services". The UM Program Description states that the plan does not require a written referral for specialist claim payments, a provider may enter a standing referral with a specialist as in the Policy.	(With DHH approval, ACLA does not require members to receive a written PCP referral to see a specialist.)	N/A	
6.28.2.5	Process for member referral for case management;	Met The Plan's Integrated Care Management Program encompasses Episodic Care Management and Complete Care Management integrated with Chronic Care Management components.	156.202 ICM Referral	Section "Purpose" Paragraph 2	Page 1
6.28.2.6	Process for member referral for chronic care management;	Met The Plan's Integrated Care Management Program encompasses Episodic Care Management and Complete Care Management integrated with Chronic Care Management components.	156.202 ICM Referral	Section "Purpose" Paragraph 2	Page 1
6.28.2.7	Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.	Met The Provider Manual states that "PCPs are prohibited from making referrals to healthcare entities with which they or a member of their family has a financial relationship".	Provider Manual	Additional PCP Responsibilities	Page 21
6.28.2.8	Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.	Met The document states "PCPs should maintain a medical record of all services rendered by the PCP and other specialty providers".	Provider Manual	Section II –Provider Office Standards & Requirements	Page 11
6.28.2.9	There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and	Met The document states that the Provider is responsible "To monitor and follow-up on care provider by other medical service providers for diagnosis and treatment". It also states that "PCPs should maintain a medical record of all services rendered by the PCP and other specialty providers".	Provider Handbook	Section II –Provider Office Standards & Requirements	Page 11
6.28.2.10	Process for referral of members for Medicaid State Plan services that are excluded from MCO core benefits and services and that will continue to be provided through fee-for-service Medicaid.	Met The document states "Amerihealth Caritas Louisiana Staff identify the need for services outside of those covered by Amerihealth Caritas work through the ICM department to facilitate coordination of care".	156.701 Coordination with Other Services	Section "Procedure" and Attachment B	Page 3
6.28.2.11	The MCO shall develop electronic, web-based referral processes and systems.	Met The plan provided screenshots of Navinet's online referral system that address this requirement. Navinet is the plan's provider portal.			
6.29					

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.29.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH. The MCO shall ensure member-appropriate PCP choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a MCO member may encounter.	Met The Coordination With Other Services policy outlines the process to coordinate the Plan's covered services and other services for the Plan's Members. Pages 3-4 discuss in detail the procedures used by the Plan to coordinate care. The Discharge Planning policy addresses how the Plan "facilitates coordination of healthcare services and health management activities to support a safe and successful discharge from the acute care facility to post acute care services. Pages 2-4 discuss the care coordination procedure followed by the Plan. The policy discusses the procedure the Plan utilizes to coordinate care when the member transitions another Provider, Coordinated Care Network or Medicaid Fee for Service. The Policy addresses how the Plan provides continuing coverage of care for Members who are engaged in an ongoing course of treatment with a non-participating Provider to promote continuity of care including Newly Enrolled Pregnant Women and Newly Enrolled Members.	156.701 Coordination with Other Services (See 6.28) 156.800 Care Transition: Discharge Planning 156.301 Care Transition: Plan or Provider Change UM.706LContinuity of Care	Section "Procedure" Section "Policy" Paragraphs: 1 – 2 Section "POLICY" Section "Purpose" Paragraphs 1; Section "Procedure" Policy Section	Page 3 -4 Page 1, Page 2-3 Page 1, 2-4 Page 2
6.29.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208.	Met The Coordination With Other Services policy outlines the process to coordinate the Plan's covered services and other services for the Plan's Members. Pages 3-4 discuss in detail the procedures used by the Plan to coordinate care. The Policy addresses how the Plan provides continuing coverage of care for Members who are engaged in an ongoing course of treatment with a non-participating Provider to promote continuity of care including Newly Enrolled Pregnant Women and Newly Enrolled Members.	156.701 Coordination with Other Services (See 6.28) 156.301 Care Transition: Plan or Provider Change	Section "Procedure" Section "policy" paragraph 1 Section "Purpose"	Pages 3 – 4 Page 1 Pages 2-4
6.29.2	The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:	Met The requirement is addresses in the following sections below.	N/A (Intro to P&P requirements)		

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.29.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Met The P/P 124.12.010 Assigning PCP (p.2) states that "all new members are assigned to their chosen PCP or automatically assigned to a PCP based on DHH-approved algorithms".	124.12.010 Assigning PCP	Section "Purpose"	Page 2
6.29.2.2	Coordinate care between PCPs and specialists;	Met The Provider Manual states that providers are responsible "to provide the coordination necessary for the referral of members to specialists and for the referral of members to services available through Louisiana Medicaid". It also states that providers will "monitor and follow-up on care provided by other medical services providers for diagnosis and treatment".	Provider Manual	Provider Responsibilities	Page 11
6.20.2.3	Coordinate care for out-of-network services, including specialty care services;	Met The Coordination With Other Services P/P outlines the process to coordinate the Plan's covered services and other services for the Plan's Members. Pages 3-4 discuss in detail the procedures used by the Plan to coordinate care.	156.701 Coordination with Other Services (See 6.28)	Section "Procedure"	Pages 3 - 4
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	Met The Coordination With Other Services P/P outlines the process to coordinate the Plan's covered services and other services for the Plan's Members. Pages 3-4 discuss in detail the procedures used by the Plan to coordinate care.	156.701 Coordination with Other Services (See 6.28)	Section "Procedure"	Pages 3 - 4
6.29.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	Met The Care Transition: Discharge Planning P/P addresses how the Plan "facilitates coordination of healthcare services and health management activities to support a safe and successful discharge from the acute care facility to post acute care services. Pages 2-4 discuss the care coordination procedure followed by the Plan.	156.800 Care Transition: Discharge Planning	Section "Policy" Section "Procedure"	Page 1 Page 2-3
6.29.2.6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, and other applicable state or federal laws;	Met The Care Transition: Discharge Planning P/P and Care Transition: Plan or Provider Change P/P address the Plan's processes and policies for safeguarding the privacy of the Plan's members.	156.800 Care Transition: Discharge Planning 156.301 Care Transition: Plan or Provider Change	Section "Policy" Paragraphs 4-6 Section "Policy" Paragraphs 4-6	Page 2 Page 2
6.29.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Met The Care Transition: Discharge Planning P/P addresses how the Plan "facilitates coordination of healthcare services and health management activities to support a safe and successful discharge from the acute care facility to post acute care services. Pages 2-4 discuss the care coordination procedure followed by the Plan.	156.800 Care Transition: Discharge Planning	Section "Policy" paragraph 1 Section "Purpose" Paragraph 1	Page 1 Page 2
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge;	Met The Care Transition: Discharge Planning P/P addresses how the Plan "facilitates coordination of healthcare services and health management activities to support a safe and successful discharge from the acute care facility to post acute care services. Pages 2-4 discuss the care coordination procedure followed by the Plan.	156.800 Care Transition: Discharge Planning	Section "Procedure" Numbers 1- 2	Page 2- 3

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.29.2.9	Document authorized referrals in its utilization management system; and	Met The P/P UM.904L: Authorization for OON Providers addresses how requests for out-of-network providers are processed and decisions communicated to providers are documented in the Plan's system.	UM.904L: Authorization for OON Providers (See 6.28)	Section Procedure	Page 3-4
6.29..10	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less;	Met The P/P 159.301 Provider Termination states that "It is the Plan's policy to make sure members are transitioned to another PCP or Specialist ensuring continuity of care when their practitioner's contract has been terminated, voluntarily or involuntarily. Members may continue an ongoing course of treatment with a Practitioner whose contract is terminated with the Plan (either by the Plan for reasons other than cause or by the Practitioner) for up to ninety (90) days from the date that the Member is notified by the Plan of the termination or pending termination."	159.301 Provider Termination	Policy Section	Page 1
6.30					
6.30.1	In the event a Medicaid eligible entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.	Met: The policy states that for Newly Enrolled Members "Who are receiving medically necessary covered services the day before becoming an ACLA Member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. ACLA will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the Member may be reasonably transferred without disruption, whichever is less. ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider.	UM. 706L Continuity of Care	Policy Section Bullet #2	Page 2
6.30.2	In the event a Medicaid eligible entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.	Met According to the P/P UM. 706L Continuity of Care, women who are in the first trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA Member, can continue to receive such medically necessary prenatal care services, including prenatal care, delivery, and postpartum care, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider until such time as ACLA can reasonably transfer the Member to a participating ACLA Practitioner/Provider without impeding service delivery that might be harmful to the Member's health.	UM. 706L Continuity of Care	Policy Section Bullets #1,	Page 1

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.30.3	In the event a member entering the MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) days postpartum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.	Met The UM. 706L Continuity of Care P/P states that members "Who are in the second or third trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA Member can continue to receive services from their prenatal care Practitioner/Provider (whether a participating or non-participating ACLA Practitioner/Provider) through the postpartum period, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the postpartum period."	UM. 706L Continuity of Care	Policy Section Bullet #1	Page 1
6.30.4	The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services.	Met All of the policies submitted referenced state "Member Hold Harmless. Provider shall accept the final payment made by ACL as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by ACL, the insolvency of ACL, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACL acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement."	TEMPLATE_PCP_Srvs_Agmt_V1_LA_ FINAL_REBRAND 01162014 _TEMPLATE Specialist Srvs _LA_FINAL REBRAND 01162014 TEMPLATE Hospital Srvs Agmt_V1_LA_FINAl REBRAND 01162014 TEMPLATE Ancillary Srvs Agmt_V1_LA FINAL REBRAND 01162014 TEMPLATE RHC_FQHC PCP AGMT_V1_LA _FINAL REBRAND 01162014	Section 9.6 Section 9.6 Section 9.6 Section 9.6 Section 9.6	
6.31					
.31.0	For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as prior authorization shall not be required for approval.	Met The Provider Manual states that "PCPs should discuss plans for future pregnancy with female members who are able to become pregnant…Base4d on the member's desire to become pregnant, the practitioner should assist the Member in obtaining appropriate family planning and/or health services to assist the Member in achieving her plan with optimal health status." Family Planning is addresses on pg 41 and states that "members are covered for family planning services without a referral or prior authorization."	Provider Manual	Section II Provider Office Standards & requirements – Pregnancy Planning	Pg. 13, pg 41
6.32					

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.32.0	In the event a Medicaid/CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.	Met The UM.706LContinuity of Care P/P states that those "Who are receiving medically necessary covered services the day before becoming an ACLA Member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. ACLA will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the Member may be reasonably transferred without disruption, whichever is less. ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider."	UM.706LContinuity of Care	Policy Section Bullet #2	Page 2
6.3					
6.3.2	**Formulary-** The MCO is required to have a Formulary that follows the minimum requirements below:				
6.3.2.1	The Formulary shall be kept up-to-date and available to all providers and members via MCO web site and electronic prescribing tools.	Met The P/P PTFD-2-06 Formulary Management (p.6) states that "PerformRx provides access to an update, plan approved formulary via the web based search formulary. The formulary is continuously updated to reflect the most recent formulary changes."	PTFD-2-06 Formulary Management	Written Notifications of Formulary Changes	Page 6
6.3.2.3	The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request.	Met The P/P PTFD-2-06 Formulary Management (p.1) states that the "formulary, and any changes to it, are implemented, maintained and monitored on a quarterly basis".	PTFD-2-06 Formulary Management	Policy Section	Page 1
6.3.2.8	The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs.	Met The P/P DRUM-2-02 Prior Authorization of Prescription Medications addresses the Plan's prior approval process to obtain a decision regarding coverage of a drug that requires prior authorization.	DRUM-2-02 Prior Authorization of Prescription medications		Page 1 Page 18: Attachment E
6.3.3	**Preferred Drug List**				
6.3.3.6	The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs.	Met The P/P DRUM-2-02 Prior Authorization of Prescription Medications addresses the Plan's prior approval process to obtain a decision regarding coverage of a drug that requires prior authorization.	DRUM-2-02 Prior Authorization of Prescription medications		Page 1 Page 18: Attachment E
6.33					
6.33.1	The MCO must submit for approval, a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services or enrollment in the MCO's plan. The MCO shall continue any treatment of antidepressants and antipsychotics for at least 60 days after enrollment into the MCO's plan. Additionally, an enrollee that is, at the time of enrollment, in the MCO receiving a prescription drug that is not on the MCO's Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days.	Met According to the P/P 151.001 Pharmacy Continuity of Care, "AmeriHealth Caritas Louisiana will continue treatment of maintenance medications for at least 60 days after a member's enrollment into the plan. AmeriHealth Caritas Louisiana will continue any treatment of antidepressants and antipsychotics for at least 60 days after a member's enrollment into the plan. Additionally, an enrollee that is, at the time of enrollment, receiving a prescription drug that is not on the AmeriHealth Caritas Formulary shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days."	151.001 Pharmacy Continuity of Care	Policy, page 1	

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.34					
6.34.1	The PCP shall provide basic behavioral health services (as described in this section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	Met The 156.900 BH Behavioral Health Referral/Coordination with SMO and Primary Care Providers P/P states that "The PCP shall provide basic behavioral health (BH) services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized BH services."	156.900 BH Behavioral Health Referral/Coordination with SMO and Primary Care Providers	Section "Purpose" paragraph 1	Page 1
6.34.2	The MCO shall establish a formal memorandum of understanding with the SMO, effective the begin date of the contract, to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs.	Met The Magellan ACLA MOU document addresses the agreement between Magellan Health Services Inc and Amerihealth Caritas Louisiana Inc for Continuity and Integration of Behavioral Healthcare with General Medical Care. The 156.701 Coordination with Other Services P/P addresses requesting "the member's consent to share information regarding the member's needs and care plan with behavioral health providers".	Magellan ACLA MOU 156.701 Coordination with Other Services (See 6.28)	Sections All Section "Procedure" Number 3	Pages 1-6 Page 4
6.34.3.	In order to ensure continuity and coordination of care for members who have been determined by a medical provider to need specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the MCO shall be responsible for referring to the SMO.	Met The requirement is addressed in P/P 156.900 BH Behavioral Health Coordination with SMO and PCPs; MCO responsibilities, page 2, bullet #2.	156.900 BH Behavioral Health Coordination with SMO and PCPs	MCO responsibilities	Page 2
6.34.4	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. Payment for the emergency service is the responsibility of the MCO, payment for any follow-up care is the responsibility of the SMO.	Met The P/P 156.900 BH Behavioral Health Coordination with SMO and PCPs states "If a member is in need of emergency behavioral health services, Amerihealth shall instruct the member to seek help from the nearest emergency medical provider AmeriHealth Caritas Louisiana shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. "	156.900 BH Behavioral Health Coordination with SMO and PCPs	Emergency Coordination	Page 7
6.34.5	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	Met The P/P UM.905L Emergency Room Services (p.2) addresses post stabilization services. It states "Post stabilization services provided to the member subsequent to the emergency medical services and treatment that are medically necessary, require authorization from the plan. The determination by the plan for the provision or denial of these services will be made within one (1) hour from the initial request. Post-stabilization services that are approved by the plan cannot be reversed. Requests for post-stabilization authorization that are not responded to within one (1) hour from initial request, or if the plan	UM.905L Emergency Room Services	Procedure Section, Post Stabilization	Page 2

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
		was not available at the time of initial request, will be covered without the requirement of prior authorization regardless of provider's contract status.			
6.34.6	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider.	Met The P/P 156.900 BH Behavioral Health Coordination with SMO and PCPs (p.5) addresses obtaining the member's consent, coordination of care with the SMO and PCP and documenting the attempts made to engage the member's cooperation and permission to coordinate the member's overall plan of care with the SMO.	156.900 BH Behavioral Health Coordination with SMO and PCPs	Procedure, Section 3 Referral process to SMO	Page 5
6.34.7	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	Met Policies 156.900 BH Behavioral Health Coordination with SMO and PCPs and 156.701 Coordination with Other Services fully address the requirement for coordinating care and continuity of care for behavioral health providers.	156.900 BH Behavioral Health Coordination with SMO and PCPs 156.701 Coordination with Other Services (See 6.28)	Section "Procedure" Section "Procedure"	Pages 4-7 Page 3-4
6.34.8	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.	Met The P/P 156.900 BH Behavioral Health Coordination with SMO and PCPs states "In cases where there are chronic/complex medical needs and behavioral needs, significant barriers to treatment or barriers to discharge from a hospitalization, AmeriHealth Caritas Louisiana will collaborate with medical providers, hospital, SMO, to access appropriate behavioral and physical health services."	156.900 BH Behavioral Health Coordination with SMO and PCPs	Section "Policy"	Page 1
6.34.9	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	Met The P/P 156.900 BH Behavioral Health Coordination with SMO and PCPs states "The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures". The ACLA Provider Orientation 2015 presentation states that the Plan conducts "training of providers and care managers on identification and screening of behavioral health conditions and referral procedures". Members are identified through utilization and disease management programs, member service referrals, provider referrals, claims history and predictive modeling software.	156.900 BH Behavioral Health Coordination with SMO and PCPs ACLA Provider Orientation 2015	Section "Procedure" Number 7 Slide 19	Page 2
6.35					
6.35.0	In the event a Medicaid member entering the MCO is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before MCO enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred (within timeframe specified in this RFP) without	Met The requirement is addressed in P/P UM.706L Continuity of Care; "Policy" section 2 Newly Enrolled Members.	UM.706L Continuity of Care	Policy Section	Page 2

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
	disruption, whichever is less. The MCO must also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the MCO.				
6.36					
6.36.1	The MCO shall provide active assistance to members when transitioning to another MCO or to Medicaid FFS.	Met The P/P 156.301 Care Transition: Plan or Provider Change addresses this requirement. It explains how the Plan "provide assistance to members when transitioning to another provider, Coordinated Care Network or Medicaid Fee for Service".	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section Purpose, Procedure	Page 2-4
6.36.2	The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO unless the member has been identified as an ISHCN (see section 6.32 for exception of ISHCN.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Policy" Paragraph 1	Page 1
6.36.3	If a member is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure" #1 & #2	Page 3

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.36.4	Upon notification of the member's transfer, the receiving MCO shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving MCO shall be the responsibility of the relinquishing MCO. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing MCO's PCP within ten (10) business days of the receiving MCO's PCP's request.	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure" #5	Page 3
6.36.4.1	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	Met The requirement is fully addressed in the P/P UM.706L Continuity of Care.	UM.706L Continuity of Care (See 6.29)	Policy Section Bullet #2 Newly Enrolled Members	Page 2
6.36.4.2	During transition, the MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.	Met The requirement is fully addressed in the P/P UM.706L Continuity of Care.	UM.706L Continuity of Care (See 6.29)	Policy Section Bullet #1 Newly Enrolled Pregnant Women and #2 Newly Enrolled Members	Page 2
6.36.5	Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Procedure	Page 3, #6 & #8
6.36.7	Special consideration should be given to, but not limited to, the following:				
6.36.7.1	Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure" #10(i)	Page 3
6.36.7.2	Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure" #10(ii)	Page 3

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.36.7.3	Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change	Section "Procedure" #10(iii, iv)	Page 3
6.36.7.4	Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure" #10(iv)	Page 3
6.36.8	When relinquishing members, the MCO is responsible for timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members. The MCO, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with MCO and service information, emergency numbers and instructions on how to obtain services.	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change. Page 4 of the policy states "As the receiving CCN, the Plan is responsible to coordinate care with the relinquishing Contractor for Members with special needs, so services are not interrupted, and for providing new Members with information about our Plan, available services, emergency numbers and instructions on how to obtain services.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section "Procedure"	Page 4
6.37					
6.37.1	The MCO shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, social services, and basic behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.	Met The requirement is fully addressed in the ICM Program Description 2014 and the P/P 156.201 ICM Standards of Practice.	ICM Program Description 2014 156.201 ICM Standards of Practice (See 6.28)	Section "2014 Integrated Care Management Program Description Section "Policy"	Page 17 Pages 1-3
6.37.2	Case Management program functions shall include but not be limited to:				
6.37.2.1	Early identification of members who have or may have special needs;	Met: The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that the "Membership is analyzed according to aid category. The aid categories include: Breast and Cervical Cancer, Family and Children, Foster Care, La CHIP and SSI. Additional DSTHS Care Analyzer reports are created monthly to identify membership changes related to asthma, diabetes, obesity, cardiovascular disease and sickle cell."	156.201 ICM Standards of Practice (See 6.28)	Section "Policy"	Page 1; paragraph 4

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.37.2.2	Assessment of a member's risk factors;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that "Upon referral to CCM Program the Member is assessed to collect information and identify individual strengths, needs and risk factors related to health status; condition-specific issues; clinical history and medication use; activities of daily living and functional status; mental health status (including cognitive functions); life-planning activities; cultural and linguistic needs, preferences and limitations; visual and hearing needs, preferences and limitations; caregiver resources and involvement; and available benefits."	156.201 ICM Standards of Practice (See 6.28)	Section "Policy"	Page 2 Paragraph 1
6.37.2.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that the "care plan interventions include education on….routine Medical Home/PCP/Specialist visits".	156.201 ICM Standards of Practice (See 6.28)	Section "Policy"	Page 2; Paragraph 2
6.37.2.4	Development of an individualized treatment plan, in accordance with Section 6.18.4;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28)	Section "Care Plan"	Page 3
6.37.2.5	Referrals and assistance to ensure timely access to providers;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that the purpose of the policy includes "timely facilitation of referrals & resources and timely access to providers".	156.201 ICM Standards of Practice (See 6.28)	Section "Purpose"	Page 3
6.37.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28)	Section "Procedure"	Page 8; Number 14
6.37.2.7	Monitoring;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that "The CM monitors services and resources provided on an on-going basis for quality, quantity and effectiveness, to evaluate the need for revision and when evaluating Member/family cooperation."	156.201 ICM Standards of Practice (See 6.28)	Section "Policy"	Page 2, 10 number 21
6.37.2.8	Continuity of care; and	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28)	Section "Procedure"	Page 8 Number 14
6.37.2.9	Follow-up and documentation.	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states that "Care Plan goals, Interventions and self-management activities are communicated with the Member, PCP and other appropriate members of the treatment team." Documentation and follow-up is addressed in the Procedure section page 9 #17, #19.	156.201 ICM Standards of Practice (See 6.28)	Section "Policy" Section "Procedure"	Page 2 Paragraphs 4-5 Page 9 Numbers 17; 19E
6.38					
6.38.0	The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	Met The requirement is addressed in the Plan's stating that the Plan will submit for DHH approval.	161.002 Creation & Approval of Communications Material	Section "Procedure", #11c, #12, #13	Page 4
6.38.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Met The requirement is fully addressed in the P/P 156.202 ICM Referral. The policy states member are	156.202 ICM Referral	Purpose	Page 1

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
		referred to the ICM program including self-referral by a member and/or referral from the PCP, Specialist or other provider.			
6.38.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Met The requirement is fully addressed in the P/P 156.202 ICM Referral.	156.202 ICM Referral (See 6.28)	Section "Procedure"	Page 2
6.38.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: • Reproductive aged women with a history of prior poor birth outcomes; and • High risk pregnant women	Met The requirement is fully addressed in the document High Risk Pregnancy Workflow.	High Risk Pregnancy Workflow High Risk Pregnancy Workflow (Addendum)	Complete document Section "Acuity"	Page 1 Page 1
6.38.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28)	Sections "Purpose" Definitions	Pages 3- 4
6.38.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states "The CM establishes a rapport with the Member and/or Member family, friend, caretaker in order to effectively collaborate with the Member in creating an effective Care Plan."	156.201 ICM Standards of Practice (See 6.28)	Section "Policy" Procedure	Page 2 Paragraph 1-3 Page 6 #11
6.38.6	Procedures and criteria for making referrals to specialists and subspecialists;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The policy states "The CM assists Members with referrals to specialist and subspecialist, services and resources covered by AmeriHealth Caritas Louisiana and available in the community, and facilitates follow-up to identify whether the Member has connected with the recommended resources."	156.201 ICM Standards of Practice (See 6.28)	Section "Policy	Page 2 Paragraph 4
6.38.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and	Met The requirement is fully addressed in the P/P 156.301 Care Transition: Plan or Provider Change.	156.301 Care Transition: Plan or Provider Change (See 6.29)	Section Procedure	Page 3 # 4,6,7,8,9
6.38.8	Coordinate Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	Met The requirement is fully addressed in the P/P 156.202 ICM Referral.	156.202 ICM Referral (See 6.28)	ICM Programs	Page 3
6.39					

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.39.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	Met The requirement is fully addressed in the CCMP Blueprints documents and the P/P 156.300 CM CC Blended Model.	CCMP Blueprints: Asthma Cardiovascular Disease Diabetes HIV Hepatitis Obesity (Adult & Ped) Sickle Cell 156.300 CM CC Blended Model (See 6.38)	All Sections	All Pages
6.39.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.	Met The requirement is fully addressed in the CCMP Blueprints documents	CCMP Blueprints: COPD Chronic Pain	All Sections	All Pages
6.39.4	The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	Met The requirement is addressed in the Plan's documentation stating that the Plan will submit for DHH approval.	161.002 Creation & Approval of Communications Material (See 6.38)	#11d	Page 4
6.39.4.1	Include the definition of the target population;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Stratification"	Stratification pages
6.39.4.2	Include member identification strategies, i.e. through encounter data;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Stratification"	Section "Stratification"
6.39.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Supporting Clinical Guidelines"	Section "Supporting Clinical Guidelines"
6.39.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Clinical Guidelines"	
6.39.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Stratification/Intervention"	

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.39.4.6	Include methods for informing and educating members and providers;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Educational Topics & Corresponding Resources"	
6.39.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Met The requirement is fully addressed in the P/P 156.201 ICM Standards of Practice. The document states "The Complex Care Management (CCM) Program is a collaborative process of Assessment, Planning, education, facilitation, Coordination, Monitoring, Evaluation and advocacy for the options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes according to evidence based practice and clinical guidelines for specific clinical conditions."	All CCMP Blueprints 156.201 ICM Standards of Practice (See 6.28)	Section " Supporting Clinical Guidelines" Section "Complex Care Management Program"	 Page 4
6.39.4.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Met The requirement is fully addressed in the CCMP Blueprints documents	All CCMP Blueprints	Section "Importance to Louisiana Disease State	
6.39.4.9	Address co-morbidities through a whole-person approach;	Met The P/P 156.300 CM CC Blended Model states "the blended model that provides comprehensive case management and disease management services to the highest risk Members identified with targeted disease states. To provide proactive interventions that are based upon stratification levels supportive and aimed at improving clinical outcomes of the member. AmeriHealth Caritas Louisiana supports Member self-management through education, evidence-based practice, informed decision-making, collaboration with treating providers via the use of technologies with the goal of optimizing health outcomes. The model incorporates a member/caregiver-based decision support system that drives both communication and care plan development through a multidisciplinary approach to management." The document states "The Complex Care Management (CCM) Program is a collaborative process of Assessment, Planning, education, facilitation, Coordination, Monitoring, Evaluation and advocacy for the options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes according to evidence based practice and clinical guidelines for specific clinical conditions."	156.300 CM CC Blended Model (See 6.38) 156.201 ICM Standards of Practice (See 6.28)	Section "Purpose" Section "Definitions" Complex Care Management Program	Page 2 Page 4
6.39.4.10	Identify members who require in-person case management services and a plan to meet this need;	Met The P/P CC.100F Member Identification identifies members who need in person case management services as "Members eligible for the program include those individuals that require complex case management beyond that available through current telephonic and/or the ambulatory care system.	CC.100F Member Identification	Section "Procedure" Identifying Members for Community Based Case Management	Page 2-3

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
		Community Care identifies members with physical or developmental disabilities, behavioral health issues (such as drug or alcohol addiction, among others) or serious mental illness, chronic conditions and severe injuries."			
6.39.4.11	Coordinate CCMP activities for members also identified in the Case Management Program; and	Met The P/P 156.201 ICM Standards of Practice addresses the requirement for CCMP activities within the Plan's ICM program. The policy states that the purpose of the program is "the process for Members who meet criteria for Complex Care Management(CCM) services to have a systematic and consistent evaluation of the key elements of their medical, psychosocial, functional, and other health care needs; development of an individual Care Plan and prioritized goals; identification of barriers; timely facilitation of referrals and resources; timely access to providers, and ongoing Assessment of progress and needs." CCMP is one of the components of the Plan's ICM model.	156.201 ICM Standards of Practice (See 6.28)	Section "Purpose"	Page 3
6.39.4.12	Include Program Evaluation requirements.	Met The ICM Program Description 2014 states that "The ICM Program is continually evaluated to measure its effectiveness. Analysis includes comparison to the program's goals and benchmarks and assessment of the program's strengths to identify opportunities for improvement and provide recommendations for the future. ACLA monitors key indicators for the ICM Program. Data is collected, analyzed and reported to QAPIC. At least annually, data from all components is collected and analyzed to evaluate the effectiveness of the program as a whole. The evaluation assesses all aspects of the program including, but not limited to, program scope; identification and engagement of members; efficiency of service; process and outcome measures; and identification of opportunities for improvement. The annual evaluation is prepared by key stakeholders in ICM, reviewed by the Director of Integrated Care Management and ACLA Medical Director and reviewed and approved by the QCCC and QAPIC."	ICM Program Description 2014 (See 6.37)	Section "Program Evaluation"	Page 22
6.40					
40.1	The MCO shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.	Met The ICM Program Description 2014 states that on an annual basis, member population and subpopulation are assessed and reviewed using internal reports to update the Plan's ICM program. The policy states that the Plan uses data mining which includes "Current and historic medical and pharmacy claim data are analyzed to identify members belonging to targeted chronic condition populations. ACLA's algorithms incorporate analysis of medical, behavioral health (as available) and pharmacy claims to identify members who are actively diagnosed with the condition, and avoid false-positive identification of members who are being ruled-out for a condition."	ICM Program Description 2014 (See 6.37)	Section "Policy" Paragraph 4	Pages 9-10
6.40.2	The MCO shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include but are not limited to:	Met The ICM Program Description 2014 and the P/P 156.201 ICM Standards of Practice address the requirement.	ICM Program Description 2014 (See 6.37) 156.201 ICM Standards of Practice (See 6.28)	Section "Population Identification and Stratification" Section "Procedure" Numbers 20 - 22	Page 9-10 Pages 9-10

Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
6.40.2.1	A brief history of the tool's development and historical and current uses;	Met The requirement is fully addressed in the ICM Program Description 2014 and the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28) ICM Program Description 2014 (See 6.37)	Section "policy" Paragraph 4 Section "Data Mining"	Page 1 Page 10
6.40.2.2	Medicaid data elements to be used for predictors and dependent measure(s);	Met The requirement is fully addressed in the Care Analyzer Training slides.	Care Analyzer Training	All	All
6.40.2.3	Assessments of data reliability and model validity;	Met The requirement is fully addressed in the Care Analyzer Training slides.	Care Analyzer Training	All	All
6.40.2.4	A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and	Met The requirement is fully addressed in the ICM Program Evaluation 2014.	ICM Program Evaluation 2014	Section "Identification and Stratification"	Page 4-5
6.40.2.5	A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.	Met The requirement is fully addressed in the Care Analyzer Training slides and the P/P 156.201 ICM Standards of Practice.	156.201 ICM Standards of Practice (See 6.28) Care Analyzer Training	All	All