Amerigroup Louisiana, Inc.

2016 Compliance Audit

Review Period: September 2015 – August 2016

Issued April 2017

Prepared on Behalf of
The State of Louisiana
Louisiana Department of Health

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

TABLE OF CONTENTS

Report Content

This report includes the following sections:

Section 1: Background and Introduction

Section 2: Summary report that details each element and corresponding domain for which the plan received a review determination less than fully compliant.

Section 3: Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Section 1: Introduction and Audit Overview

INTRODUCTION

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct Annual Compliance Audits every three years, followed by partial audits in the intervening years. The 2016 Annual Compliance Audit was a full audit of MCO compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

This report presents IPRO's findings of the 2016 Annual Compliance Audit for Amerigroup Louisiana, Inc.(Amerigroup).

AUDIT OVERVIEW

The purpose of the audit was to assess Amerigroup's compliance with federal and state regulations regarding access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The audit included a comprehensive evaluation of Amerigroup's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing/Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, care management, utilization management, provider credentialing, and communication between the MCO and member and provider communities.

Specifically, file review consisted of the following seven (7) areas:

1. Appeals
2. Behavioral Health Care Management
3. Case Management
4. Informal Reconsiderations
5. Member Grievances
6. Provider Credentialing/Recredentialing
7. Utilization Management Denials

Sample sizes for each file review type are presented in **Table 1**.

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Behavioral Health Care management	10
Case Management	10
Informal Reconsiderations	5
Member Grievances	10
Provider Credentialing	5
Provider Recredentialing	5
Utilization Management Denials	10

The period of review was September 1, 2015 through August 31, 2016. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," and "compliance not met" were used for each element under review. The definition of each of the review determinations is presented in **Table 2**.

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The MCO has met or exceeded the standard.
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

The 2016 Annual Compliance Audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared nine (9) review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in October 2016. The tools included the review elements drawn from the state and federal regulations. Upon reviewing the tools, LDH recommended elements to be added to the review tools to ensure completeness. Based upon the LDH's suggestions, the tools were revised, incorporating the elements added by LDH, and issued as final. These final tools were submitted to the MCO in October 2016 in advance of the onsite audit. All Medicaid MCOs in Louisiana were audited using the same review tools.

Once LDH approved the methodology, IPRO sent Amerigroup a packet that included the review tools along with a request for documentation and a guide to help MCO staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure FTP site.

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

Prior to the onsite visit, the MCO submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The MCO was given a period of approximately four weeks to submit documentation to IPRO. To further assist MCO staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs undergoing the audit, with LDH staff in attendance, approximately one week after the request packet was sent to the MCOs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline and answered any questions posed by MCO staff.

After the MCO submitted the required documentation, a team of three (3) experienced IPRO auditors was convened to review the MCO's policies, procedures and materials and assess their concordance with the state's contract

requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the onsite review discussion.

Onsite Visit

The onsite component of the audit was comprised of a two (2) day onsite visit, which included a review of elements in each of the nine (9) review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited Amerigroup in December 7–8, 2016 to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and for the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy was conducted in accordance to state standards.

Post-onsite Report Preparation

Following the onsite audit, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that the standard was met or a rationale for why the standard was not met and what evidence was lacking. For each element not fully compliant, IPRO provided a recommendation for the MCO to consider in order to attain full compliance.

Each draft report underwent a second level of review by IPRO staff not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval the draft reports were sent to the MCO with a request to furnish any additional documentation for all elements that were determined to be less than fully compliant. The MCO was given approximately two weeks to respond to the issues noted on the draft reports.

After receiving the MCO's response and any additional documentation, IPRO re-reviewed each element for which the MCO provided a response and missing documentation. As a result, several elements' review scores were either raised or converted to "Full Compliance" based on the additional documentation submitted and the reports were issued as final.

Section 2: MCO Summary of Findings

SUMMARY OF FINDINGS

Table 3 below provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	N/A	% Full
Core Benefits and Services	123	121	2	0	0	0	98%
Provider Network	163	155	5	3	0	0	95%
Utilization Management	92	90	1	0	0	1	99%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing/Member Education	77	76	0	0	0	1	100%
Member Grievances and Appeals	62	55	4	3	0	0	89%
Quality Management	86	85	0	0	0	1	100%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	104	1	0	0	0	99%
TOTAL	**722**	**700**	**13**	**6**	**0**	**3**	**97%**

As displayed in the above, 722 elements were reviewed; 13 were determined to be "substantially met" and 6 were "minimally met." None received a "not met" determination. Three elements were not applicable. The remaining 700 elements were "fully met." The overall compliance score was 97%.

It is IPRO's and the LDH's expectation that Amerigroup submit a corrective action plan for each of the 19 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that, in response to the compliance audit draft findings, Amerigroup has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Eight (8) of the 19 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Amerigroup**.**

IPRO extracted from each of the nine detailed reports each element that the MCO was found to be less than fully compliant into a summary report to facilitate corrective action. This summary report includes each element reviewed, the final review determination, the MCO's initial response and suggestions to achieve full compliance.

Table 4: Deficient Audit Domains for Amerigroup

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
Core Benefits and Services					
6.38.2.4	Development of an individualized treatment plan, in accordance with Section 6.19.4;	Case Management – LA CM Program Description	Substantial	This requirement is met through the documents: Case Management – LA, page 1 CM Program Description, page 16 <u>File review</u> 19/20 case management files include individualized treatment plans. In response to the draft report, Amerigroup Louisiana, Inc. indicated that it will begin auditing care plans to ensure that they reflect policy. Review determination is unchanged.	Care Plans completed on members in Complex Case Management. Members in Regulatory, Stabilization or Care Coordination do not require a care plan to be completed. **<u>Action Plan</u>** PIE Audits will be utilized to ensure associates are creating care plans as per policy. Any findings identified in this report will be used to trigger one-on-one training with associates.
6.38.3.1	The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with	Member Services Functions Case Management – LA CM Program Description	Substantial	This requirement is met through the documents: Case Management – LA, page 2 Member Services Functions, page 1 And CM Program Description, page 8 <u>File review</u> 9/10 physical case management files included a comprehensive needs assessment. One file included a limited evaluation of needs, with only positive behavioral health needs documented. This member was also included in the Behavioral Health case management files, which include only a limited assessment and references physical health needs that are not addressed in a care plan. The remaining physical case management files	Care Plans completed on members in Complex Case Management. Members in Regulatory, Stabilization or Care Coordination do not require a care plan to be completed. **<u>Action Plan</u>**: PIE Audits will be utilized to identify incomplete or not revised care plans as per policy. Noncompliance with policy will trigger one-

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.			include a care plan; however, in three files it appears that not all identified problems are addressed in the care plan. It is not clear from documentation whether this is due to no current need for intervention for these issues. All case management files with a care plan (9/9) included short and long term goals and monitoring of whether goals were met. Only two of 10 physical case management files documented a change in status; one care plan was revised with updated medication status. The remaining file did not include a revision, although preterm contractions and medication prophylaxis were documented in notes. **Recommendation for Amerigroup Louisiana, Inc.** The plan should ensure that all case management files include a care plan and that identified needs and status changes are addressed in the care plan. The plan could consider including a column in its physical and behavioral health case management summary section for documentation of outcomes monitoring for each need noted in the file. In response to the draft report, Amerigroup Louisiana, Inc. indicated that it will begin auditing care plans to ensure that they reflect policy. Review determination is unchanged.	on-one training with associates.
Provider Network					
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members.	Network Provider Development and Management Plan Appendix TT Network Provider Development and	Substantial	Geo Access Report Results This requirement is addressed on pages 6 through 9 of the Provider Network Accessibility Analysis Policy. Deficiencies are noted in the Geo-Access results below. The plan submitted the Network Adequacy	PH Q4 2016 Geo Access Rpt Submission Cover Lttr (Pages 1-3) Q3 Geo Access Q4 Geo Access

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Specialists included under this requirement are listed in Appendix TT – Network Providers by Specialty Type. DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) - Requests for exceptions LAGeo3Q16 Appendix UU		Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. <u>Geo-Access Report Results</u> Specialists Standard – travel distance not to exceed 60 miles for at least 75% of members; not to exceed 90 miles for all members <u>Deficiencies</u> Pediatric Critical Care Medicine – 76.1% within 60 miles (meets the standard) 91.9% access within 90 miles (deficient) Pediatric Emergency Medicine 68.7% access within 60 miles (deficient) 76.7% access within 90 miles (deficient) Pediatric Endocrinology 86.5% access within 60 miles (meets the standard) 96.4% access within 90 miles (deficient) Pediatric Gastroenterology 89.5% access within 60 miles (meets the standard) 99.9% access within 90 miles (deficient) Pediatric Hematology 80.5% access within 60 miles (meets the standard) 89.2% access within 90 miles (deficient) Pediatric Infectious Disease 87.3% access within 60 miles (meets the standard) 96.4% access within 90 miles (deficient) Pediatric Nephrology 85.3% access within 60 miles (meets the standard) 98.1% access within 90 miles (deficient)	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Pediatric Pulmonology 93.8% access within 60 miles (meets the standard) 99.7% access within 90 miles (deficient) Pediatric Rheumatology 39.9% access within 60 miles (deficient) 52.5% access within 90 miles (deficient) Pediatric Sports Medicine 84.2% access within 60 miles (meets the standard) 98.3% access within 90 miles (deficient) Rheumatology 90.1% access within 60 miles (meets the standard) 95.3% access within 90 miles (deficient) Surgery Colon and Rectal 84.9% access within 60 miles (meets the standard) 91.6% access within 90 miles (deficient) Surgery – Neurological 92 % access within 60 miles (meets the standard) 99.9% access within 90 miles (deficient) Surgery – Plastic 95.1% access within 60 miles (meets the standard) 99.7% access within 90 miles (deficient) <u>Areas that meet the access standards</u> Allergy/Immunology Anesthesiology Audiology Cardiology Chiropractic Dermatology Emergency medical Endocrinology Gastroenterology Hematology/Oncology Hospice Infectious Disease	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Neonatology Nephrology Neurology Nuclear Medicine Obstetrics Ophthalmology Occupational Therapy Optometry Orthopedics Otolaryngology Pathology Pediatric Allergy Pediatric Cardiology Pediatric Surgery Personal Care Physical Therapy Podiatry Pulmonary Medicine Speech Therapy Surgery – Cardiovascular Surgery – General Surgery – Thoracic Urology Onsite, each of the specialties that did not meet the standard was discussed. In each case, the plan is aware of the need and has taken steps to try to improve network adequacy. The universe of many of the pediatric subspecialties is very small (e.g., pediatric rheumatology, there are only two in the state). The plan has conducted network comparisons with Blue Cross in an attempt to recruit Blue Cross Providers that serve commercial. The plan also incentivizes providers to join the network. **Recommendation for Amerigroup Louisiana, Inc.**	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Plans may want to consider collaborating, with the LDH's support, to recruit providers in areas of need since this problem impacts all Medicaid health plans in the state. Perhaps using a unified approach will help in the MCOs' efforts to recruit providers who are reluctant to join Medicaid managed care in the state, explaining to them the significant unmet needs and the increase in long term healthcare costs to all residents in the state if these unmet needs are left unattended. A task force comprised of representatives of all five plans and perhaps LDH as well can be convened to help develop strategies to recruit providers. In its response to the draft report, Amerigroup included its narrative report discussing strategies to address deficiencies in its network. In this document, Amerigroup stated that it will continue "contracting efforts using the list of specialists purchased from the LA State Board of Medical Examiners, Provider Partners and other provider directories to improve our provider network. Furthermore, Amerigroup is building a data base with our vendor, Strenuus, to help ascertain availability of deficient provider types by region. This will help us respond more quickly to deficiencies and more accurately report issues in these areas." With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA	Substantial	<u>Geo Access Report Results</u> This requirement is addressed in the Network Provider Development and Management Plan on page 21. <u>Geo-Access Report Results</u> Lab and Radiology	Amerigroup Louisiana, Inc. will revise the methodology used to create the Geo Access map for lab and radiology by revising our current configuration within FACETs to include all

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Standards and Measures & Monitoring Appropriate Accessibility to Care Policy LAGeo3Q16 Appendix UU		Standard (rural – travel distance not to exceed 30 miles); 88.1% members have access (deficient) Standard (urban – travel distance not to exceed 20 miles); 96.8% members have access Onsite, the lack of Labs and Radiology services was discussed. The plan did not report a quality of care problem with lab and radiology services. Some labs are located outside of the state and do not count toward the distance standards. Others are hospital-based, which cannot be currently captured by the GeoAccess reports, at this time **Recommendations for Amerigroup Louisiana, Inc.** Though it requires a system modification to FACETS, if practical, the plan should work toward including hospital-based labs that provide outpatient services to more accurately represent the availability of such services. In its response to the draft report, Amerigroup Louisiana, Inc. indicated it is moving forward with plans to revise FACETS to include all hospital-based labs that provide hospital services in the expectation that this change will help identify and contract with new providers. The review determination remains unchanged.	hospital-based labs that provide outpatient services. We will also continue to look for opportunities to contract freestanding labs within our network.
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures &	Substantial	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Geo-Access Report Results Standard - rural – travel distance not to exceed 30 miles Deficiency	Q3 Q4 BH Geo Access Rpt Submission Cover (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU		Psychologists 83.5% access within 30 miles <u>Areas that meet the access standards</u> APRN/CNS BH Specialists Psychiatrists PRTF Addiction PRTF Hospital Based Therapists Onsite, this area was discussed. Amerigroup Louisiana, Inc. is aware of the deficiency in its Psychologist network. The universe is small and they are difficult to recruit. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** IPRO suggests initiating an incentive program to attract Psychologists to join the network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess	Substantial	<u>Geo Access Report Results</u> This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. <u>Geo Access Report Results</u> Standard - urban – travel distance not to exceed 15 miles <u>Deficiency</u> Psychologists 83.5% access within 15 miles <u>Areas that meet the access standards</u> APRN/CNS BH Specialists	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Report Appendix UU		Psychiatrists Psychiatric Resident Treatment Facility (PRTF) PRTF Addiction PRTF Hospital Based Therapists Psychologists 88.8% access within 10 miles (deficient) Onsite, this area was discussed. The plan acknowledged the lack of Psychologists in its network and is working to enhance recruitment. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Minimal	<u>Geo Access Report Results</u> This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. The plan submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. <u>Geo-Access Report Results</u> Clinically Managed High Intensity Level III.5 Standard - travel distance not to exceed 30 miles for 90% of adult members and not to exceed 60 miles for adolescent members <u>Deficiencies</u> Adult access is 66.9% Adolescent access is 67% Onsite, this area was discussed. Amerigroup Louisiana, Inc. acknowledged the deficiency. There are very few of these types of facilities in the state	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				and the plan has contracts with most of them. It is working to recruit those facilities not currently in its network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Minimal	<u>Geo Access Report Results</u> This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Amerigroup Louisiana, Inc. submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. <u>Geo Access Report Results</u> Medically Monitored Intensive Residential Level III.7 Standard - travel distance not to exceed 60 miles for 90% of adult members <u>Deficiency</u> Adult access is 62.4% Onsite, this area was discussed. Amerigroup Louisiana, Inc. acknowledged the deficiency. There are very few of these types of facilities in the state and the plan has contracts with most of them. It is working to recruit those facilities not currently in its network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed	Network Provider Development and Management Plan	Minimal	<u>Geo Access Report Results</u> This requirement is addressed in the Network	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2)

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	60 miles for 90% of adult members.	Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU		Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Amerigroup Louisiana, Inc. submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. <u>Geo-Access Report Results</u> Medically Monitored Residential Detox Level III.7D Standard - travel distance not to exceed 60 miles for 90% of adult members <u>Deficiency</u> Adult access is 13.6% Onsite, this area was discussed. Amerigroup Louisiana, Inc. acknowledged the deficiency. There are very few of these types of facilities in the state and Amerigroup Louisiana, Inc. has contracts with most of them. It is working to recruit those facilities not currently in its network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	Q3 Geo Access Report Q4 Geo Access Report
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Substantial	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 1 and 5. During file review onsite, one of the 10 credential files reviewed was missing the DEA or CDS certificate but it appears that the standard was checked. The other nine files contained all of the required documentation so the omission was not due to a systematic problem. In its response to the draft report, Amerigroup Louisiana, Inc. noted that only one file was missing the DEA/CDS certificate and this was due to an	The health plan follows the requirements of NCQA section CR 3. Amerigroup Louisiana, Inc. utilizes the NTIS database and/or generates copies of the CDS from the Louisiana Board of Pharmacy for files presented. The document was inadvertently missing from the file. As noted

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.			oversight. No systematic issue was observed and no change in procedure I required. The review determination is unchanged.	by the reviewer, all files, including the file in question, had the standard checked.
Utilization Management					
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	Clinical Information for Utilization Management Reviews – Core Process – LA Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA	Substantial	Written procedures to address the failure to provide the necessary information for review are detailed in the plan's Concurrent review policy. However, the plan does not specify the timeframe for denying the authorization or whether the plan has a defined timeframe. According to the regulations, "the MCO may deny authorization of the requested service(s) within two (2) business days." In its response to the draft report, Amerigroup Louisiana, Inc. submitted revised policies to reflect the additional language. Review determination is unchanged since the revisions were made after the review period.	Concurrent Review (Telephonic and On-site) and On-Site Review Protocol Process – LA; Page 7 -8; Procedures – Insufficient Clinical Information - Language added to reflect MCO may deny auth of requested services within two business days. Clinical Information for Utilization Management Reviews – Core Process – LA; Page 7; Insufficient Clinical Information Added: "The MCO may deny authorization of the requested service(s) within two (2) business days in cases where the provider or member will not release necessary

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					information."
Member Grievances and Appeals					
13.2.4.2	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Substantial	This requirement is addressed in Member Appeals-Core Process-LA, page 11, Member Complaints and Grievances-LA, page 5 and Member Handbook, pages 56-59. Per Member Complaints and Grievances-LA, page 5, forms for filing grievances, appeals, concerns or recommendations will be made available on the member website. The MCO member website was reviewed and includes forms for requesting fair hearing, appeal and continuation of benefits. These forms are available in English and Spanish. The website does not include a form for filing a grievance. Under the section "Newsletters and more" on the website, members are provided a link to submit comments to AMG. Grievances are not addressed. The plan provided an appeal form for review, but grievance forms were not available for review. **Recommendation for Amerigroup Louisiana, Inc.** The plan should make forms for filing grievances available to members as per requirement. In its response to the draft report, Amerigroup Louisiana, Inc. is making provisions to update its website. Review determination is unchanged.	Job Request e-mail for posting grievance form on member website Grievance Form A job request to have the member grievance form uploaded to both the public and secure member website. An expedited request was submitted – completion date by April 2017 as a change needed be made to the document.
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO	Member Complaints and Grievances - LA	Substantial	Member Complaints and Grievances-LA, page 6 addresses "DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal," but does not address "The MCO will be responsible for promptly	Member Complaints and Grievances – LA; Procedure, Page 6 – added text to reflect MCO's responsibility to

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.			forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member." As per onsite staff, a DHH request would come through the regulatory email inbox and would be responded to immediately. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** The MCO should include prompt submission of adverse decisions to LDH for review on request by LDH or MCO member in policy. In its response to the draft report, Amerigroup Louisiana, Inc. added text to reflect its responsibility to forward adverse decisions to LDH. Since the revision was made after the review period, the review determination is unchanged.	promptly forward any adverse decisions to LDH
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Substantial	Addressed in Member Complaints and Grievances-LA, page 6. Member Appeals-Core Process-LA, page 18 partially addresses this requirement. Under Handling of Appeals, 1, e, ii. The policy states "who, if deciding any of the following…" "Any of the following" is not defined, e.g., an appeal of a denial that is based on lack of medical necessity, an appeal that involves clinical issues. <u>File review</u> 10/10 appeals and 3/3 applicable grievances were reviewed by appropriate clinical staff. It was not clear in one grievance file whether a clinical issue was involved, and the case did not appear to be referred for clinical review. Onsite staff demonstrated an updated tracking database that has been developed for grievances	Member Appeals Core Process – LA; # e(ii), Page 17 of 25 – the policy was revised to reflect the requirement language.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				in which it is clear which are referred to other departments for review and resolution of the additional review. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** The plan should update the Member Appeals-Core Process policy to include the required language and continue to maintain the updated tracking process for grievances. In its response to the draft report, Amerigroup Louisiana, Inc. revised its policy to reflect the required language. Since the revision was made after the review period, the review determination is unchanged.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal	Minimal	The Member Appeals-Core Process-LA, page 18, does not address opportunity to present in person, only in writing. Page 20 addresses opportunity to present evidence in writing as well as in person for expedited appeals. The Member Handbook addresses this requirement on page 56. Page 56 informs the member of the opportunity to appeal and submit a written request including information such as the care you are looking for, people involved, and having their doctor submit medical information about this service. Onsite staff provided an updated Member Handbook with an insert dated May 2016 that addresses the requirement to provide the member reasonable opportunity to present evidence, and allegations of fact or law, in person. Neither the submitted denial notice template nor acknowledgment letter templates address this requirement. However, updated letter templates dated 9/12/16	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes Member Handbook, Expedited Appeals; printed pages 57-58 The statement “If you are requesting an expedited resolution, please be advised of the limited time available to present evidence in person and in writing” was added to the appeal acknowledgment letters and the member handbook.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				were provided onsite for review and are compliant, though outside the review period. The Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal states that upon receipt of an appeal, the plan attempts to phone the member to obtain information verbally if no information is submitted with the appeal. If the member has information to submit, the member is advised to submit the information in writing (fax number provided) or member can bring information in person to the plan. During the call, the member is informed of the limited time available for expedited appeals. If the member cannot be reached by phone, the plan processes the appeal using the original information provided. The denial notice template, acknowledgment letter templates and Member Handbook do not inform the member that they will be contacted by phone. <u>File review</u> 10/10 appeals files did not include information relevant to presenting evidence in person. These cases predate the updated letter templates. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** The plan should implement updated denial and appeal letter templates that include required language. The plan should include the limited time available for presenting evidence for expedited appeals in denial letters and the Member Handbook. In its response to the draft report, Amerigroup Louisiana, Inc. revised the Member Handbook and Appeal letters. Since the revision was made after the review period, the review determination is unchanged.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services Desktop Process: Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal	Minimal	Member Appeals-Core Process-LA, page 18, addresses this requirement. Neither the submitted denial notice template nor acknowledgment letter templates address this requirement. The appeal resolution notice (upheld) informs the member that the standards used to decide the appeal and the documents and data collected in reviewing the appeal are available to the member. This is not sufficient since the appeal is already completed at this point. The Member Handbook update provided onsite addresses this requirement on page 3. The Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal states that upon receipt of an appeal, the plan attempts to phone the member. During the phone call, the member is advised of this opportunity. **Recommendation for Amerigroup Louisiana, Inc.** The denial notice and acknowledgment letters should advise the member of their opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. In its response to the draft report, Amerigroup Louisiana, Inc. revised the acknowledgement letters. Since the revision was made after the review period, the review determination is unchanged.	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes The statement "member and his or her representative have the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process" was added to the acknowledgement letters.
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition Grievances.** The MCO will provide written notice to the member of the disposition of a grievance.	Member Appeals – Core Process – LA	Substantial	For grievances, partially addressed in Member Complaints and Grievances-LA, page 6 and Member 14-day Extension notice, page 4 and page 6. This policy does not specifically state that the notice is provided in writing. Grievance Resolution	Member Complaints and Grievances – LA; Policy Page 1; Timeliness for Filing, Page 7 - Added "written

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Appeals. For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	Member Appeal Upheld Letter Member Appeal Overturned Letter Member Complaints and Grievances - LA Grievance Resolution Letter		Letter template addresses this requirement. For appeals, the requirement is addressed in Member Appeals-Core Process-LA, pages 20-21, Member Appeal Upheld Letter and Member Appeal Overturned Letter. <u>File review</u> 11 of 15 reviewed grievance files included written notices of disposition. Three of the remaining files originated at LDH, and the plan indicated that they do not sent written notices for grievances that originate at LDH. The other remaining file did not include a resolution notice. 10/10 reviewed appeals files met this requirement. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** The plan should consider initiating a process to ensure that the plan is aware that grievances referred from LDH are resolved and members notified of resolution. Internally received complaints should all receive written notices of resolution, and this requirement for written notice should be included in policy. For two of the grievances, the issue involved assignment of a PCP who was not accepting patients. The plan should ensure that trends that are identified are investigated as to systematic issues that may be generating complaints. In its response to the draft report, Amerigroup Louisiana, Inc. indicated that is currently tracks and trends grievances monthly and updated its policy to reflect required language. It is recommended that the plan closely monitor grievances that are reported and implement a process to ensure that when members request a	resolution" as well as text reflecting resolution letter All Grievances are tracked and trended and reported monthly. An internal trending of complaints is analyzed quarterly to identify reoccurring or high trending issues as well as providers

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				new provider that they are accepting new patients. Perhaps member services staff should be trained/retrained on identifying providers with open panels before a new PCP is assigned. Since the revision to policy was made after the review period and one of the 15 case files reviewed did not include a resolution letter, the review determination is unchanged.	
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Desktop Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal	Minimal	This information is provided verbally to the member per the "Desktop Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal." If the member is not reached by phone, it is not clear how the member is informed of this requirement. Neither the Denial Notice nor Acknowledgement Letter templates address this requirement. **<u>Recommendation for Amerigroup Louisiana, Inc.</u>** The plan should include the limited time available for presenting evidence for expedited appeals in denial letters. In its response to the draft report, Amerigroup Louisiana, Inc. revised the acknowledgement letter. Since the revision was made after the review period, the review determination is unchanged.	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes This was added to the acknowledgment letters.
Fraud, Waste and Abuse					
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Disclosure of Ownership Form 1.9.15	Substantial	This requirement is partially met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322, Section 15. Fraud, Waste, and Abuse Prevention, page 122. However, the MCO should add the language regarding ownership of subcontractors and business transactions to their documents. In its response to the draft report, Amerigroup	Medicaid Subcontractors Disclosure of Ownership; full document

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.			Louisiana, Inc. created a new policy, dated 12/30/16 regarding disclosure of ownership. Review determination is unchanged since the policy ID is dated after the review period.	

Section 3: MCO Final Audit Tools

Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**				
6.4.5 6.4.5.1	**Permanent Supportive Housing** DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Bayou Health members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388. Overall management of the PSH program is centralized within DHH and final approval for members to participate in PSH is made by the DHH PSH program staff. For the Louisiana PSH program, the MCO shall:				
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member Handbook: Integrated Health Services, Permanent Supportive Housing-LA DESKTOP PROCESS	Full	This requirement is met through document: Member Handbook: Integrated Health Services page 32 and the Permanent Supportive Housing-LA DESKTOP PROCESS page 1	
6.4.5.1.2	Assist members in completing the PSH program application;	Member Handbook: Integrated Health Services, Permanent Supportive Housing-LA DESKTOP PROCESS	Full	This requirement is met through document: Member Handbook: Integrated Health Services page 32 and the Permanent Supportive Housing-LA DESKTOP PROCESS page 1.	
6.4.5.1.3	Within one (1) working day of request by designated DHH PSH program staff, provide accurate information about status of	06.04.05.01.03_email_response_redacted	Full	This requirement is met through document:06.04.05.01.03_email_response_redacted	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	eligibility assessment, determination, and recertification;				
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the DHH PSH program manager; and	Amerigroup September DHH PSH referral report	Full	This requirement is met through document: Amerigroup September DHH PSH referral report	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:				
6.4.5.2.1	Identify a PSH program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Plan LA Org Chart	Full	This requirement is met through document: Plan LA Organizational Chart	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.	LAPEC-1019-16 New Provider Orientation Deck Provider Handbook Behavioral Health New Provider Orientation Deck Provider Education and Communication	Full	This requirement is met through document: LAPEC-1019-16 New Provider Orientation Deck, slide 45 Also through the: Provider Handbook, page 13, and page 59. For the behavioral health requirement, the regulation is addressed via the Behavioral Health New Provider Orientation Deck and Provider Education and Communication	
6.4.9.1	The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider Handbook LAPEC-1019-16 New Provider Orientation Deck	Full	This requirement is met through document: Provider Handbook, page 13 and 15 Also through the LAPEC-1019-16 New Provider Orientation Deck, page 36	
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals	Provider Handbook	Full	This requirement is met through the document: Provider Handbook, page 15-16.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.				
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	Behavioral Health Emergency Care	Full	This requirement is met through the document: Behavioral Health Emergency Care Police, pages 1-2	
6.8	**Emergency Medical Services and Post Stabilization Services**				
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Member Handbook: Integrated Health Services Pre-Certification of Requested Services-LA	Full	This requirement is met through the document: Member Handbook, page 18, 33 and page 42 Also through: the Pre-Certification of Requested Services policy, page 10 the Behavioral Health Emergency Care-policy, page 10 the 2016 UM program Description, page 54	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Behavioral Health Emergency Care-policy 2016 UM program Description			
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member Handbook: Integrated Health Services, Behavioral Health Emergency Care-policy 2016 UM program Description	Full	This requirement is met through the documents Member Handbook: Integrated Health Services, page 42-43 Behavioral Health Emergency Care-policy, page 6 the 2016 UM program Description, page 54	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Member Handbook: Integrated Health Services Pre-Certification of Requested Services-LA Behavioral Health Emergency Care-policy 2016 UM program Description	Full	This requirement is met through the documents: Behavioral Health Emergency Care-policy, page 6 the Member Handbook: Integrated Health Services, page 43 Policy: Pre-Certification of Requested Services-LA, page 10 the 2016 UM program Description, page 54	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	Member Handbook: Integrated Health Services Behavioral Health Emergency Care-policy	Full	This requirement is met through the documents: Behavioral Health Emergency Care-policy, page 6 the Member Handbook: Integrated Health Services, pages 18, 33, and 42-43	
6.8.1.5	The attending emergency physician, Licensed	Behavioral Health Emergency	Full	This requirement is met through the	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	Care-policy 2016 UM program Description		documents: Behavioral Health Emergency Care-policy, page 6 The 2016 UM program Description, page 54	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	Behavioral Health Emergency Care-policy	Full	This requirement is met through the document: Behavioral Health Emergency Care-policy, page 6	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	Member Handbook: Integrated Health Services Behavioral Health Emergency Care-policy	Full	This requirement is met through the documents: Behavioral Health Emergency Care-policy, pages 6-7 the Member Handbook: Integrated Health Services, page 42	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member Handbook: Integrated Health Services Behavioral Health Emergency Care-policy	Full	This requirement is met through the documents: Behavioral Health Emergency Care-policy, page 7 The Behavioral Health Member handbook, LA page 25	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency	Member Handbook: Integrated Health Services Behavioral Health Emergency Care-policy	Full	This requirement is met through the documents: Behavioral Health Emergency Care-policy, page 7	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.			the Behavioral Health Member handbook, LA page 25	
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member Handbook: Integrated Health Services Behavioral Health Emergency Care-policy	Full	This requirement is met through the document: Behavioral Health Emergency Care-policy, page 7.	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:				
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	Coverage for Post Stabilization Care Services	Full	This requirement is met through the document: Coverage for Post Stabilization Care Services, page 6	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	Coverage for Post Stabilization Care Services	Full	This requirement is met through the document: Coverage for Post Stabilization Care Services, page 6	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	Coverage for Post Stabilization Care Services 2016 UM program Description	Full	This requirement is met through the document: Coverage for Post Stabilization Care Services, page 6 The 2016 UM program Description, page 30	
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a	Coverage for Post Stabilization Care Services Member Handbook	Full	This requirement is met through the document: Coverage for Post Stabilization Care Services, pages 6-7 Member Handbook, page 24	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.				
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	Coverage for Post Stabilization Care Services Member Handbook	Full	This requirement is met through the documents: Coverage for Post Stabilization Care Services, page 7 The Member Handbook, page 24	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	Coverage for Post Stabilization Care Services Member Handbook	Full	This requirement is met through the documents: Coverage for Post Stabilization Care Services, page 7 the Member Handbook, page 24	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	Coverage for Post Stabilization Care Services Member Handbook	Full	This requirement is met through the documents: Coverage for Post Stabilization Care Services, page 7 the Member Handbook, page 24	
6.8.2.2.4	The member is discharged.	Coverage for Post Stabilization Care Services Member Handbook	Full	This requirement is met through the documents: Coverage for Post Stabilization Care Services, page 7 the Member Handbook, page 24	
6.19	**Services for Special Populations**				
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk,				

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:				
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;				
6.19.1.2	Individuals with intravenous drug use;				
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders;				
6.19.1.4	Substance using women with dependent children;				
6.19.1.5	Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;				
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and				
6.19.1.7	Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.				
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). DHH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.	Special Needs Population - Policy Case Management Program Description PASRR Workflow Behavioral Health Pre-Admission Screening and Resident Review (PASRR) - LA	Full	This requirement is met through the documents: Special Needs Population – Policy, page 3 The Case Management document The Program Description, page5 And the Behavioral Health Pre-Admission Screening and Resident Review (PASRR). Recommendation: The PASRR Workflow document should be reviewed and updated with an approval date.	PASRR workflow approved by MAC on 3/2/17 E-mail documenting approval
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that	LALA_CAID_BH_Outpatient_treatment form	Full	This requirement is partially through the document:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: • The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, DHH approved, guidelines for SHCN criteria. • MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. • Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. • Members may be identified by DHH and that information provided to the MCO.	Special Needs Population - Policy		Special Needs Population – Policy, page 4	
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan and a person-centered plan of care. The individualized treatment plans must be:	Special Needs Population – Policy MHR WORKFLOW	Full	This requirement is met through the documents: Special Needs Population – Policy, page 4 the MHR WORKFLOW	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	CM Program Description	Full	This requirement is met through the document: Special Needs Population LA policy, page 3, procedure 2	
6.19.4.2	In compliance with applicable quality assurance and utilization management standards.	CM Program Description	Full	This requirement is met through the document: CM Program Description, page 8	
6.19.4.3	SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a person- centered plan of care that includes all medically necessary services including specialized behavioral health services identified in the member's treatment plan.	Case Management - LA CM Program Description	Full	This requirement is met through the document: Case Management – LA, page 1-2 File review	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				1/1 applicable files met this requirement.	
6.27	**Care Management**				
6.27.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	Member Handbook: Integrated Health Services Care Coordination, Continuity of Care and Care Transition – LA Special Needs Population – LA Case Management Program Description	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 5 The Special Needs Population-LA, page 1 The Case Management Program Description, page 6	
6.27.2 6.27.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	Member Handbook	Full	This requirement is met through the document: Member Handbook, pages 8-12 File review 10/10 case management files met this requirement.	
6.27.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	Member Handbook	Full	This requirement is met through the document: Member Handbook, pages 8-12	
6.27.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	06.27.02.03 Supporting Clinical Care Coordination, Continuity of Care and Care Transition – LA Case Management Program Description	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 8 The Case Management Program Description, pages 7, 12 File review All relevant case management files met this requirement.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.27.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	Behavioral Health Continuity and Coordination of Care- LA CM Program Description	Full	This requirement is met through the documents: Behavioral Health Continuity and Coordination of Care- LA, page 4 The CM Program Description, page 10	
6.29	**Care Coordination, Continuity of Care, and Care Transition**				
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 or DHH's dental benefit program manager. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, 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 through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.	Risk Screener Adult Risk Screener Pedi Risk Screen BH Only Adult Risk Screener BH Only Pedi Continuity of Care - LA	Full	This requirement is met through the documents: Continuity of Care – LA, pages 2-3 Risk Screener Adult and, Risk Screener Pedi, Risk Screen BH Only Adult, and the Risk Screener BH Only Pedi	
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. In addition,	Care Coordination, Continuity of Care and Care Transition - LA	Full	This requirement is met through the document: Care Coordination, Continuity of	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.			Care and Care Transition – LA, pages 5-6	
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:				
6.29.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Continuity of Care - LA	Full	This requirement is met through the document: Continuity of Care – LA, page 3	
6.29.2.2	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA CM Program Description	Full	This requirement is met through the documents: Continuity of Care – LA, page 3 the CM Program Description, page 17 the Care Coordination, Continuity of Care and Care Transition – LA, page 1	
6.29.2.3	Coordinate care for out-of-network services, including specialty care services;	Continuity of Care – LA CM Program Description Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 3 Care Coordination, Continuity of Care and Care Transition – LA, page 5 the CM Program Description, page 35	
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	Continuity of Care - LA Case Management Program Description	Full	This requirement is met through the document: Continuity of Care – LA, page 3 the Case Management Program Description, pages 5,6,8,16,17 Care Coordination, Continuity of Care and Care Transition – LA, page 5	

Core Benefits and Services					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Care Coordination, Continuity of Care and Care Transition – LA			
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;	Continuity of Care – LA Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the document: Continuity of Care – LA, page 3 the Care Coordination, Continuity of Care and Care Transition – LA, page 5	
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, and other applicable state or federal laws;	Continuity of Care – LA CM Program Description Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 3 The CM Program Description, pages 8, 32 the Care Coordination, Continuity of Care and Care Transition – LA, page 5	
6.29.2.7	Maintain and operate a formalized hospital	Continuity of Care – LA	Full	This requirement is met through the	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	and/or institutional discharge planning program;	CM Program Description Care Coordination, Continuity of Care and Care Transition – LA		documents: Continuity of Care – LA, page 3 The CM Program Description, page 8 the Care Coordination, Continuity of Care and Care Transition – LA, page 5	
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA CM Program Description 6.29 Screenshot	Full	This requirement is met through the documents: Continuity of Care – LA, page 4 Care Coordination, Continuity of Care and Care Transition – LA, pages 5&6 CM Program Description, page 35 the 6.29 Screenshot	
6.29.2.8.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	Behavioral Health - Hospital Discharge Coordination Process for Pharmacy – LA Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA CM Program Description 6.29 Screenshot	Full	This requirement is met through the documents: Behavioral Health - Hospital Discharge Coordination Process for Pharmacy – LA, page 3 Care Coordination, Continuity of Care and Care Transition – LA, page 6 Continuity of Care – LA, page 4 CM Program Description, page 14 the 6.29 Screenshot	
6.29.2.8.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	Care Coordination, Continuity of Care and Care Transition – LA Behavioral Health Stabilization / Discharge	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA , page 6	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Planning Process 6.29 Screenshot		Behavioral Health Stabilization / Discharge Planning Process, page 1 the 6.29 Screenshot	
6.29.2.8.3.	Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA CM Program Description	Full	This requirement is met through documents: Care Coordination, Continuity of Care and Care Transition – LA, page 6 Continuity of Care – LA, page 4 CM Program Description, page 8	
6.29.2.9	Document authorized referrals in its utilization management system; and	Continuity of Care – LA Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 4 Care Coordination, Continuity of Care and Care Transition – LA, page 6	
6.29.2.10	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.	Continuity of Care - LA Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 4 Care Coordination, Continuity of Care and Care Transition – LA, page 6, section j	
6.29.2.11	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing.	Continuity of Care – LA Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 4 Care Coordination, Continuity of Care and Care Transition – LA, page 6	
6.29.2.12	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the documents:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Continuity of Care – LA CM Program Description		Care Coordination, Continuity of Care and Care Transition – LA, page 6 Continuity of Care – LA, page 4 The CM Program Description, page 8	
6.35	**Continuity for Behavioral Health Care**				
6.35.1	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.	Care Coordination, Continuity of Care and Care Transition – LA CM Program Description	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, pages 3 and 7 the CM Program Description, page 15	
6.35.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state	Continuity of Care – LA	Full	This requirement is met through the document: Continuity of Care – LA, page 8	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	laws and other applicable standards of medical record confidentiality and the protection of patient privacy.				
6.35.3	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.	Behavioral Health ID Card Care Coordination, Continuity of Care and Care Transition – LA CM Program Description Continuity of Care – LA LA-MEM-0274-15 LA ENR BH Recip.Carrier Letter ID Card	Full	This requirement is met through the documents: Continuity of Care – LA, pages 8 and 9 Behavioral Health ID Card Care Coordination, Continuity of Care and Care Transition – LA, page 8 CM Program Description, page 8 the LA-MEM-0274-15 LA ENR BH Recip.Carrier Letter ID Card	
6.35.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 8 Continuity of Care – LA, page 9	
6.35.5	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 and primary care provider.	Care Coordination, Continuity of Care and Care Transition – LA CM Program Description 6.35.5 Screenshot Continuity of Care – LA	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA page 8 CM Program Description, page 12 6.35.5 Screenshot, page 1 Continuity of Care – LA, page 9 <u>File review</u> All applicable physical and behavioral health case management files addressed this requirement.	
6.35.6	The MCO shall provide procedures and criteria for making referrals and coordinating	Care Coordination, Continuity of Care and Care Transition –	Full	This requirement is met through the documents:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	LA CM Program Description Continuity of Care – LA		Continuity of Care – LA, page 9 Care Coordination, Continuity of Care and Care Transition – LA, page 8 CM Program Description, page 7 <u>File review</u> All applicable physical and behavioral health case management files addressed this requirement.	
6.35.7	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 providers, facilities and agencies and require complex coordination of benefits and services.	CM Program Description Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the document: CM Program Description, page 7 and Recommendation: The MCO should add "children with special health care needs" to the following policy: Care Coordination, Continuity of Care and Care Transition – LA, page 8. In its response to the draft report Amerigroup stated that it added the required language to the Policy.	Care Coordination Continuity of Care and Care Transition – LA; Policy; Page 9 of 10. # 15 - Revised to include ''or children with special health care needs'
6.35.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	LAPEC-1019-16 New Provider Orientation Deck Continuity of Care – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 9 LAPEC-1019-16 New Provider Orientation Deck, page 45	
6.35.9 6.35.9.1.1 6.35.9.1.2 6.35.9.1.3 6.35.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-	Care Coordination, Continuity of Care and Care Transition – LA CM Program Description	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 1 CM Program Description, page 18 Continuity of Care – LA, page 9	Care Coordination Continuity of Care and Care Transition – LA; Policy; Page 2 of 10 - Revised to include 'with the MCO Behavioral Health Case Management team - Changed monthly to yearly as needed

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co- management.	Continuity of Care – LA			
6.35.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 2 Continuity of Care – LA, page 10	
6.35.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	LAPEC-1019-16 New Provider Orientation Deck Continuity of Care – LA	Full	This requirement is met through the document: Continuity of Care – LA, page 10 LAPEC-1019-16 New Provider Orientation Deck, page 26	
6.35.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	Member Handbook: Integrated Health Services LAPEC-1019-16 New Provider Orientation Deck Continuity of Care – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 10 Member Handbook: Integrated Health Services, pages 42-43 LAPEC-1019-16 New Provider Orientation Deck, page 45	
6.35.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	Care Coordination, Continuity of Care and Care Transition – LA CM Program Description	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 2 Continuity of Care – LA, page 10	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Continuity of Care – LA		CM Program Description, page 12	
6.35.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	Care Coordination, Continuity of Care and Care Transition – LA CM Program Description Continuity of Care – LA	Full	This requirement is met through the documents : Care Coordination, Continuity of Care and Care Transition – LA, page2 CM Program Description, page 31 Continuity of Care – LA, page 10 section I	
6.35.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Care Coordination, Continuity of Care and Care Transition – LA Continuity of Care – LA	Full	This requirement is met through the documents: Care Coordination, Continuity of Care and Care Transition – LA, page 2 Continuity of Care – LA, page 10 <u>File review</u> All applicable case management files addressed this requirement.	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	Continuity of Care – LA	Full	This requirement is met through the document: Continuity of Care – LA, page 10	
6.35.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Care Coordination, Continuity of Care and Care Transition – LA LAPEC-1019-16 New Provider Orientation Deck Continuity of Care – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 10 Care Coordination, Continuity of Care and Care Transition – LA, pages 2 and 9 LAPEC-1019-16 New Provider Orientation Deck, page 45	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	Care Coordination, Continuity of Care and Care Transition – LA	Full	This requirement is met through the document: Continuity of Care – LA, page 10	• Care Coordination Continuity of Care and Care Transition – LA; Policy; Page 2 of 10. Last two bullets

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		CM Program Description Continuity of Care – LA		Recommendation: The MCO should add Behavior Health and Case Management to the Care Coordination, Continuity of Care and Care Transition-LA policy to be consistent with the Continuity of Care-LA policy. In its response to the draft report Amerigroup stated that it added the required language to the Policy	Revised to reflect language
6.35.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with DHH representatives for the purpose of coordination and communication.	Care Coordination, Continuity of Care and Care Transition – LA Agenda Notes- Magellan Amerigroup Continuity of Care – LA	Full	This requirement is met through the documents: Continuity of Care – LA, page 10 Care Coordination, Continuity of Care and Care Transition – LA, pages 2-3 Agenda Notes- Magellan Amerigroup, page 1	
6.38	**Case Management (CM)**				
6.38.1	The MCO shall develop and implement a case management program through a process which provides that appropriate and medically-related services, social services, and basic and specialized 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 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.	Case Management – LA Case Management Program Description	Full	This requirement is met through the documents: Case Management Program Description, page 1 Case Management – LA, page 1 The Contract was signed before the review period. <u>File review</u> 20/20 case management files addressed these requirements, including evidence of inclusion of member in care planning.	
6.38.2	Case Management program functions shall include but not be limited to:				
6.38.2.1	Early identification , through active outreach,	Case Management – LA	Full	This requirement is met through the	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	of members who have or may have special needs;	CM Program Description		documents: Case Management – LA, page 1 CM Program Description, page 9	
6.38.2.2	Assessment of a member's risk factors;	Case Management – LA Case Management Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 Case Management Program Description <u>File review</u> 20/20 case management files addressed this requirement.	
6.38.2.3	Education regarding patient-centered medical home and referral to a medical home when appropriate;	Case Management – LA CM Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 CM Program Description, page 8	
6.38.2.4	Development of an individualized treatment plan, in accordance with Section 6.19.4;	Case Management – LA CM Program Description	Substantial	This requirement is met through the documents: Case Management – LA, page 1 CM Program Description, page 16 <u>File review</u> 19/20 case management files include individualized treatment plans. In response to the draft report, Amerigroup Louisiana, Inc. indicated that it will begin auditing care plans to ensure that they reflect policy. Review determination is unchanged.	Care Plans completed on members in Complex Case Management. Members in Regulatory, Stabilization or Care Coordination do not require a care plan to be completed. **<u>Action Plan</u>** PIE Audits will be utilized to ensure associates are creating care plans as per policy. Any findings identified in this report will be used to trigger one-on-one training with associates.
6.38.2.5	Referrals and assistance to ensure timely access to providers;	Case Management – LA CM Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 CM Program Description, pages 7	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				and 31 File review All applicable case management files addressed this requirement.	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Case Management – LA CM Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 And CM Program Description, page 31 File review 20/20 case management files addressed this requirement.	
6.38.2.7	Monitoring;	Case Management – LA CM Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 CM Program Description, pages 12, 31 File review 20/20 case management files addressed this requirement.	
6.38.2.8	Continuity of care; and	Case Management - LA Case Management Program Description	Full	This requirement is met through the documents: Case Management – LA, page 1 Case Management Program Description, page 5 File review 20/20 case management files addressed this requirement.	
6.38.2.9	Follow-up and documentation.	Case Management - LA	Full	This requirement is met through the document: Case Management – LA, pages 1, 21 File review 20/20 case management files addressed this requirement.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.38.3	Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19. A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.	Case Management – LA CM Program Description	Full	This requirement is met through the documents: Case Management – LA, pages 1-2 CM Program Description, page 8 File review 1/1 applicable case management file addressed this requirement.	
6.38.3.1	The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.	Member Services Functions Case Management – LA CM Program Description	Substantial	This requirement is met through the documents: Case Management – LA, page 2 Member Services Functions, page 1 And CM Program Description, page 8 File review 9/10 physical case management files included a comprehensive needs assessment. One file included a limited evaluation of needs, with only positive behavioral health needs documented. This member was also included in the Behavioral Health case management files, which include only a limited assessment and references physical health needs that are not addressed in a care plan. The remaining physical case management files include a care plan; however, in three files it appears that not all identified problems are addressed in the care plan. It is not clear from documentation whether this is due to no current need for intervention for these issues.	Care Plans completed on members in Complex Case Management. Members in Regulatory, Stabilization or Care Coordination do not require a care plan to be completed. **Action Plan**: PIE Audits will be utilized to identify incomplete or not revised care plans as per policy. Noncompliance with policy will trigger one-on-one training with associates.

Core Benefits and Services					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				All case management files with a care plan (9/9) included short and long term goals and monitoring of whether goals were met. Only two of 10 physical case management files documented a change in status; one care plan was revised with updated medication status. The remaining file did not include a revision, although preterm contractions and medication prophylaxis were documented in notes. **Recommendation for Amerigroup Louisiana, Inc.** The plan should ensure that all case management files include a care plan and that identified needs and status changes are addressed in the care plan. The plan could consider including a column in its physical and behavioral health case management summary section for documentation of outcomes monitoring for each need noted in the file. In response to the draft report, Amerigroup Louisiana, Inc. indicated that it will begin auditing care plans to ensure that they reflect policy. Review determination is unchanged.	
6.39	**Case Management (CM) Policies and Procedures**				
6.39.0	The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date	Coordination of Care – LA	Full	This requirement is met through the document:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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:			Coordination of Care – LA, page 2 Contract was signed prior to the review period	
6.39.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 CM Program Description, page 20	
6.39.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 CM Program Description, pages 10,11	
6.39.3	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.	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 CM Program Description, page 10	
6.39.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment 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;	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 CM Program Description, page 30 and 35	
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Coordination of Care – LA Case Management Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 Case Management Program	2017 Case Management Program Description; Under Defining Features 2nd bullet, Page 7: added amended to include "Family members or guardians are involved in

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				Description, page 7. Recommendation: The MCO should add the language "family members or guardians are involved in treatment care planning" to the program description. In its response to the draft report, Amerigroup indicated it added the language to reflect policy.	treatment care planning. E-mail documenting MAC approval
6.39.6	Procedures and criteria for making referrals to specialists and subspecialists;	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 2 CM Program Description, page 7	
6.39.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	Coordination of Care – LA CM Program Description	Full	This requirement is met through the documents: Coordination of Care – LA, page 3 CM Program Description, page 31	
6.39.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	Coordination of Care – LA	Full	This requirement is met through the document: Coordination of Care – LA, page 3	
6.40	**Case Management Reporting Requirements**				
6.40	The MCO shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Case Management - LA	Full	This requirement is met through the document: Case Management – LA, page 7	
6.40.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, page 7 LAPQ039_Q32016_20161005, page 1	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.40.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, page 7 LAPQ039_Q32016_20161005, page 1	
6.40.3	Number of members identified with potential special healthcare needs that self- refer;	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, page 7 LAPQ039_Q32016_20161005, page 1	
6.40.4	Number of members with potential special healthcare needs identified by the MCO;	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, pages 7-8 LAPQ039_Q32016_20161005, page 1	
6.40.5	Number of members in the lock-in program;	Case Management – LA	Full	This requirement is met through the document: Case Management – LA, page 8	
6.40.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	Case Management – LA	Full	This requirement is met through the document: Case Management – LA, page 8	
6.40.7	Number of members with assessments completed, and	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, page 8 LAPQ039_Q32016_20161005, page 1	
6.40.8	Number of members with assessments resulting in a referral for Case Management.	Case Management – LA LAPQ039_Q32016_20161005	Full	This requirement is met through the documents: Case Management – LA, page 8 LAPQ039_Q32016_20161005, page 1	
6.41	**Chronic Care Management Program (CCMP)**				
6.41.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic	Disease Management Program Description- 2016	Full	This requirement is met through the documents:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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.	Case Management – LA Asthma Disease management (DM) Program Congestive Heart Failure Disease Management (DM) Program Diabetes Disease Management Program HIV / AIDS Disease Management (DM) Program Sickle Cell Plan HepC Flyer Hep C Blank Care Plan HEP C Assessment HEP C Sickle Cell LA Obesity Screen Shots 11.16.16 DME Health Families HRA		Case Management – LA, page 8 Disease Management Program Description- 2016, page 5 Asthma Disease management (DM) Program, Full document Congestive Heart Failure Disease Management (DM) Program, Full document Diabetes Disease Management Program, Full document HIV / AIDS Disease Management (DM) Program, Full document Sickle Cell Plan, Full document HepC Flyer, Full document Hep C Blank Care Plan, Full document HEP C Assessment, Full Document HEP C, Full Document Sickle Cell, Full Document LA Obesity Screen Shots 11.16.16, Full Document DME Health Families HRA, Full Document	
6.41.3	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	Disease Management Program Description- 2016 Case Management - LA	Full	This requirement is met through the documents: Case Management – LA, pages 8-9 Disease Management Program Description- 2016.	

Core Benefits and Services					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	reports, as delineated for required chronic conditions in the CCMP, to DHH.				
6.41.4	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:	Disease Management Program Description- 2016	Full	This requirement is met through the document: The Disease Management Programs, pages 5-6	
6.41.4.1	Include the definition of the target population;	Disease Management Program Description- 2016 Disease Management (DM) Programs	Full	This requirement is met through the document: Disease Management (DM) Programs, page 2	
6.41.4.2	Include member identification strategies, i.e. through encounter data;	Disease Management Program Description- 2016	Full	This requirement is met through the document: Disease Management Program Description, 2016 (DM) Programs, pages 9, 10	
6.41.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Disease Management Program Description- 2016 Disease Management (DM) Programs	Full	This requirement is met through the document: Disease Management (DM) Programs, page 3 The Disease Management Program Description- 2016, page 6	
6.41.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	Disease Management Program Description- 2016 Disease Management (DM) Programs Member Management by Disease Management Centralized Care Unit	Full	This requirement is met through the documents: Disease Management (DM) Programs, page 2 Member Management by Disease Management Centralized Care Unit, page 1 the Disease Management Program Description- 2016, page 5	
6.41.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and	Disease Management Program Description- 2016	Full	This requirement is met through the documents:	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	associated interventions;	Disease Management (DM) Programs		Disease Management (DM) Programs, page 4 Disease Management Program Description- 2016, pages 11-12	
6.41.4.6	Include methods for informing and educating members and providers;	Disease Management Program Description- 2016 Disease Management (DM) Programs	Full	This requirement is met through the documents: Disease Management (DM) Programs, pages 1,5 Disease Management Program Description- 2016 , page 46 and 58	
6.41.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Disease Management Program Description- 2016	Full	This requirement is met through the document: Disease Management Program Description- 2016, pages 22, and 39	
6.41.4.8	Address co-morbidities through a whole-person approach;	Disease Management Program Description- 2016 Comorbid Conditions- Disease Management Program- LA	Full	This requirement is met through the documents: Comorbid Conditions- Disease Management Program- LA policy, page 1 the Disease Management Program Description- 2016, page 31	
6.41.4.9	Identify members who require in-person case management services and a plan to meet this need;	Disease Management Program Description- 2016	Full	This requirement is met through the document: Disease Management Program Description- 2016, pages 16, 22,31	
6.41.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Disease Management Program Description- 2016 Comorbid Conditions- Disease Management Program- LA	Full	This requirement is met through the document: Comorbid Conditions- Disease Management Program- LA, page 8 the Disease Management Program Description- 2016, pages 22, 31 <u>File review</u> There were no applicable case management files for this	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				requirement.	
6.41.4.11	Include Program Evaluation requirements.	Disease Management Program Description- 2016 Disease Management (DM) Programs	Full	This requirement is met through the documents: Disease Management (DM) Programs, pages 6-7 The Disease Management Program Description- 2016, page 26	
6.43	**CCMP Reporting Requirements**				
6.43.1	The MCO shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Amerigroup 42 CCMP - Reports 2016 Q3. AMG LA, Inc. - Quarterly Report Submission - Q2 2016 ENCRYPT BAYOU HEALTH Reporting_ 042 AMG 2015 Q3 ENCRYPT BAYOU HEALTH Reporting_ 042 AMG 2015 Q4 ENCRYPT BAYOU HEALTH Reporting_ Quarterly Reports for Q1 2016-Email 1 ENCRYPT	Full	This requirement is met through the documents: Amerigroup 42 CCMP - Reports 2016 Q3. AMG LA, Inc. - Quarterly Report Submission - Q2 2016 ENCRYPT BAYOU HEALTH Reporting_ 042 AMG 2015 Q3 ENCRYPT BAYOU HEALTH Reporting_ 042 AMG 2015 Q4 ENCRYPT BAYOU HEALTH Reporting_ Quarterly Reports for Q1 2016-Email 1 ENCRYPT	
6.43.2	The CCMP reports shall contain at a minimum:				
6.43.2.1	Total number of members;	LA042 AMG 2015 Q3 (CCMP State Report) Disease Management Report 072016 -092016	Full	This requirement is met through the documents: LA042 AMG 2015 Q3 (CCMP State Rep asthma tab Disease Management Report 072016 -092016	
6.43.2.2	Number of members in each stratification level for each chronic condition; and	LA042 AMG 2015 Q3 (CCMP State Report) Other quarter reports are available to show submission	Full	This requirement is met through the document: LA042 AMG 2015 Q3 (CCMP State Report), asthma tab	
6.43.2.3	Number of members who were disenrolled from program and explanation as to why they	LA042 AMG 2015 Q3 (CCMP State Report)	Full	This requirement is partially met through document:	This report is a state driven and state defined template.

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	were disenrolled.	Other quarter reports are available to show submission		LA042 AMG 2015 Q3 (CCMP State Report). The MCO should add the explanations as to why members were disenrolled to the report. In its response to the draft report, Amerigroup stated that it used a template that was state defined but is agreeable to providing the break out by program. Since the MCO used the LDH required template to report, the review determination has been revised to "fully compliant"	DMCCU utilized the correct template during the submission time period thus on the disenrollment tab - AGPLA provided LDH with the requested information and have not been provided any directive from LDH to include anything additional relative to disenrollment other than what is outlined on that tab. Therefore AGPLA maintains they were in compliance with the section standard and state required template. However, AGPLA and DMCCU are agreeable to providing the breakout by program going forward.
6.43.3 6.43.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	2015 DM LA Annual Report 101016 FINAL	Full	This requirement is met through the document: 2015 DM LA Annual Report 101016 FINAL, page 1	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**				
7.1.1	The MCO must maintain a network that ensures, at a minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Development and Management Plan Provider Network Accessibility Analysis Quarterly – LA (P/P) Physician Access (P/P) Access to Behavioral Health Care (P/P)	Full	This requirement is addressed on page 20 of the Network Provider Development and Management Plan.	
7.1.2	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Network Development and Management Plan Physician Access (P/P)	Full	This requirement is addressed on page 20 of the Network Provider Development and Management Plan.	
7.1.3	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.				
7.1.4	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Network Development and Management Plan Provider Network Accessibility Analysis Quarterly – LA (P/P) Physician Access (P/P) Access to Behavioral Health Care (P/P)	Full	This requirement is addressed on page 21 of the Network Provider Development and Management Plan.	
7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural	Network Development and Management Plan	Full	This requirement is addressed on page 21 of the Network Provider Development and Management Plan.	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.	Provider Handbook Culturally and Linguistically Appropriate Services (P/P) Linguistic Services Sample Hybrid Participating Provider Agreement		This requirement is communicated to the providers in the Provider Handbook on pages 78-79. The requirement is communicated to the members in the Member Handbook on page 9. Amerigroup provided the training materials used to make providers aware of cultural competency and the procedure used to ensure that the plan's provider network is adequately trained (Initial training of Provider on Plan's Product).	
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:				
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	Provider Handbook Physician Access (P/P) Sample Hybrid Participating Provider Agreement Member Handbook: Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 16 and to the members via the Member Handbook on page 12.	
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	Provider Handbook Physician Access (P/P) Sample Hybrid Participating Provider Agreement Member Handbook: Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 16 and to the members via the Member Handbook on page 12.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Provider Handbook Physician Access (P/P)	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 16 and to the members via the Member Handbook on page 12.	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	Provider Handbook Physician Access (P/P) Member Handbook – Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Handbook on page 17 and to the members via the Member Handbook on page 12.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	Provider Handbook Physician Access (P/P) Member Handbook – Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 18 and to the members via the Member Handbook on page 12.	
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	Provider Handbook Physician Access (P/P) Member Handbook – Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 18 and to the members via the Member Handbook on page 12.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	Provider Handbook Physician Access (P/P) Sample Hybrid Participating Provider Agreement Member Handbook – Integrated Health Services	Full	This requirement is addressed in the Physician Access Policy on page 14. This requirement is communicated to the providers in the Provider Handbook on page 17 and to the members via the Member Handbook on page 13.	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	Provider Handbook Member Handbook –	Full	This requirement is addressed on pages 73, 74, and 98 of the Provider Handbook and on page 12 of the	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Integrated Health Services		Member Handbook.	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	Provider Handbook Physician Access (P/P) Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed on page 17 of the Provider Handbook and on pages 16 and 17 of the Member Handbook.	
7.3	**Geographic Access Requirements**				
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as determined by DHH approved mapping software (*e.g.* GeoAccess). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	Network Provider Development and Management Plan Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) Provider Network Accessibility Analysis (P/P) LAGeo3Q16 Appendix UU Member Handbook – Integrated Health Services	Full	This requirement is addressed on page 8 of the Network Provider Development and Management Plan as well as in the Provider Network Accessibility Analysis Policy.	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers • Travel distance for members living in rural parishes shall not exceed 30 miles; and • Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan Provider Network Accessibility Analysis (P/P)	Full	Geo Access Report Results This requirement is addressed in the Provider Network Accessibility Analysis Policy on page 5. Geo-Access Report Results Primary Care Providers	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) LAGeo3Q16 Appendix UU		Standard (rural – travel distance not to exceed 30 miles); 100% members have access Standard (urban – travel distance not to exceed 10 miles); 98.3% members have access	
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Policy (P/P) - Requests for exceptions Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) - Requests for exceptions LAGeo3Q16 Appendix UU	Full	Geo Access Report Results This requirement is addressed on page 21 of the Network Provider Development and Management Plan. Geo-Access Report Results Acute Inpatient Hospitals Standard (rural – travel distance not to exceed 30 miles); 99.8% members have access Standard (urban – travel distance not to exceed 10 miles); 91% members have access	
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT – Network Providers by Specialty Type. DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the	Network Provider Development and Management Plan Appendix TT Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) - Requests for exceptions	Substantial	Geo Access Report Results This requirement is addressed on pages 6 through 9 of the Provider Network Accessibility Analysis Policy. Deficiencies are noted in the Geo-Access results below. The plan submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. Geo-Access Report Results	PH Q4 2016 Geo Access Rpt Submission Cover Lttr (Pages 1-3) **Q3 Geo Access** **Q4 Geo Access**

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	MCO's telemedicine utilization must be approved by DHH for this purpose.	LAGeo3Q16 Appendix UU		Specialists Standard – travel distance not to exceed 60 miles for at least 75% of members; not to exceed 90 miles for all members Deficiencies Pediatric Critical Care Medicine – 76.1% within 60 miles (meets the standard) 91.9% access within 90 miles (deficient) Pediatric Emergency Medicine 68.7% access within 60 miles (deficient) 76.7% access within 90 miles (deficient) Pediatric Endocrinology 86.5% access within 60 miles (meets the standard) 96.4% access within 90 miles (deficient) Pediatric Gastroenterology 89.5% access within 60 miles (meets the standard) 99.9% access within 90 miles (deficient) Pediatric Hematology 80.5% access within 60 miles (meets the standard) 89.2% access within 90 miles (deficient) Pediatric Infectious Disease 87.3% access within 60 miles (meets the standard) 96.4% access within 90 miles (deficient)	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Pediatric Nephrology 85.3% access within 60 miles (meets the standard) 98.1% access within 90 miles (deficient) Pediatric Pulmonology 93.8% access within 60 miles (meets the standard) 99.7% access within 90 miles (deficient) Pediatric Rheumatology 39.9% access within 60 miles (deficient) 52.5% access within 90 miles (deficient) Pediatric Sports Medicine 84.2% access within 60 miles (meets the standard) 98.3% access within 90 miles (deficient) Rheumatology 90.1% access within 60 miles (meets the standard) 95.3% access within 90 miles (deficient) Surgery Colon and Rectal 84.9% access within 60 miles (meets the standard) 91.6% access within 90 miles (deficient) Surgery – Neurological 92 % access within 60 miles (meets the standard) 99.9% access within 90 miles (deficient) Surgery – Plastic	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				95.1% access within 60 miles (meets the standard) 99.7% access within 90 miles (deficient) <u>Areas that meet the access standards</u> Allergy/Immunology Anesthesiology Audiology Cardiology Chiropractic Dermatology Emergency medical Endocrinology Gastroenterology Hematology/Oncology Hospice Infectious Disease Neonatology Nephrology Neurology Nuclear Medicine Obstetrics Ophthalmology Occupational Therapy Optometry Orthopedics Otolaryngology Pathology Pediatric Allergy Pediatric Cardiology Pediatric Surgery Personal Care Physical Therapy Podiatry Pulmonary Medicine Speech Therapy Surgery – Cardiovascular Surgery – General Surgery – Thoracic Urology	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Onsite, each of the specialties that did not meet the standard was discussed. In each case, the plan is aware of the need and has taken steps to try to improve network adequacy. The universe of many of the pediatric subspecialties is very small (e.g., pediatric rheumatology, there are only two in the state). The plan has conducted network comparisons with Blue Cross in an attempt to recruit Blue Cross Providers that serve commercial. The plan also incentivizes providers to join the network. **Recommendation for Amerigroup Louisiana, Inc.** Plans may want to consider collaborating, with the LDH's support, to recruit providers in areas of need since this problem impacts all Medicaid health plans in the state. Perhaps using a unified approach will help in the MCOs' efforts to recruit providers who are reluctant to join Medicaid managed care in the state, explaining to them the significant unmet needs and the increase in long term healthcare costs to all residents in the state if these unmet needs are left unattended. A task force comprised of representatives of all five plans and perhaps LDH as well can be convened to help develop strategies to recruit providers. In its response to the draft report, Amerigroup included its narrative	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				report discussing strategies to address deficiencies in its network. In this document, Amerigroup stated that it will continue "contracting efforts using the list of specialists purchased from the LA State Board of Medical Examiners, Provider Partners and other provider directories to improve our provider network. Furthermore, Amerigroup is building a data base with our vendor, Strenuus, to help ascertain availability of deficient provider types by region. This will help us respond more quickly to deficiencies and more accurately report issues in these areas." With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care Policy LAGeo3Q16 Appendix UU	Substantial	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 21. Geo-Access Report Results Lab and Radiology Standard (rural – travel distance not to exceed 30 miles); 88.1% members have access (deficient) Standard (urban – travel distance not to exceed 20 miles); 96.8% members have access Onsite, the lack of Labs and Radiology services was discussed. The plan did not report a quality of care problem with lab and radiology	Amerigroup Louisiana, Inc. will revise the methodology used to create the Geo Access map for lab and radiology by revising our current configuration within FACETs to include all hospital-based labs that provide outpatient services. We will also continue to look for opportunities to contract freestanding labs within our network.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				services. Some labs are located outside of the state and do not count toward the distance standards. Others are hospital-based, which cannot be currently captured by the GeoAccess reports, at this time **Recommendations for Amerigroup Louisiana, Inc.** Though it requires a system modification to FACETS, if practical, the plan should work toward including hospital-based labs that provide outpatient services to more accurately represent the availability of such services. In its response to the draft report, Amerigroup Louisiana, Inc. indicated it is moving forward with plans to revise FACETS to include all hospital-based labs that provide hospital services in the expectation that this change will help identify and contract with new providers. The review determination remains unchanged.	
7.3.5 7.3.5.1 7.3.5.2	Pharmacies • Travel distance shall not exceed 10 miles in urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) LAGeo3Q16 Appendix UU	Full	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 21. Geo-Access Report Results Pharmacy Standard (rural – travel distance not to exceed 30 miles); 100% members have access	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Standard (urban – travel distance not to exceed 10 miles); 96.3% members have access	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers • Travel distance shall not exceed 10 miles in urban areas; and • Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) LAGeo3Q16 Appendix UU	Full	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 21. Geo-Access Report Results Dialysis Centers Standard (rural – travel distance not to exceed 30 miles); 99.2% members have access Standard (urban – travel distance not to exceed 10 miles); 90.4% members have access	
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Substantial	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Geo-Access Report Results Standard - rural – travel distance not to exceed 30 miles Deficiency Psychologists 83.5% access within 30 miles Areas that meet the access standards APRN/CNS BH Specialists Psychiatrists PRTF Addiction PRTF Hospital Based Therapists	Q3 Q4 BH Geo Access Rpt Submission Cover (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Onsite, this area was discussed. Amerigroup Louisiana, Inc. is aware of the deficiency in its Psychologist network. The universe is small and they are difficult to recruit. **Recommendation for Amerigroup Louisiana, Inc.** IPRO suggests initiating an incentive program to attract Psychologists to join the network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Substantial	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Geo Access Report Results Standard - urban – travel distance not to exceed 15 miles Deficiency Psychologists 83.5% access within 15 miles Areas that meet the access standards APRN/CNS BH Specialists Psychiatrists Psychiatric Resident Treatment Facility (PRTF) PRTF Addiction PRTF Hospital Based Therapists Psychologists	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				88.8% access within 10 miles (deficient) Onsite, this area was discussed. The plan acknowledged the lack of Psychologists in its network and is working to enhance recruitment. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Minimal	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. The plan submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. Geo-Access Report Results Clinically Managed High Intensity Level III.5 Standard - travel distance not to exceed 30 miles for 90% of adult members and not to exceed 60 miles for adolescent members Deficiencies Adult access is 66.9% Adolescent access is 67% Onsite, this area was discussed. Amerigroup Louisiana, Inc.	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				acknowledged the deficiency. There are very few of these types of facilities in the state and the plan has contracts with most of them. It is working to recruit those facilities not currently in its network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Minimal	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Amerigroup Louisiana, Inc. submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. Geo Access Report Results Medically Monitored Intensive Residential Level III.7 Standard - travel distance not to exceed 60 miles for 90% of adult members Deficiency Adult access is 62.4% Onsite, this area was discussed. Amerigroup Louisiana, Inc. acknowledged the deficiency. There are very few of these types of facilities in the state and the plan has contracts with most of them. It	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				is working to recruit those facilities not currently in its network. With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Minimal	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Amerigroup Louisiana, Inc. submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will address them. Geo-Access Report Results Medically Monitored Residential Detox Level III.7D Standard - travel distance not to exceed 60 miles for 90% of adult members Deficiency Adult access is 13.6% Onsite, this area was discussed. Amerigroup Louisiana, Inc. acknowledged the deficiency. There are very few of these types of facilities in the state and Amerigroup Louisiana, Inc. has contracts with most of them. It is working to recruit those facilities not currently in its network.	Q3 Q4 BH Geo Access Rpt Submission Cover Lttr (Page 2) Q3 Geo Access Report Q4 Geo Access Report

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				With acknowledgement that the issue is one due to a lack of certain specialists available to contract, the review determination is unchanged.	
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) BH GeoAccess Report Appendix UU	Full	Geo Access Report Results This requirement is addressed in the Network Provider Development and Management Plan on page 36 and in the BH Geo Access Reports. Geo-Access Report Results PRTF Standard - travel distance not to exceed 200 miles for 90% of members Result – access is 100%	
7.3.7.7	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P)	Full	This requirement is addressed in the Network Provider Development and Management Plan on page 36	
7.3.7.8	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	Provider Network Accessibility Analysis (P/P)	Full	This requirement is addressed on page 4 of the Provider Network Accessibility Analysis Policy.	
7.4.1	Provider to Member Ratios The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in Appendix UU.	Network Provider Development and Management Plan Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate	Full	This requirement is addressed on page 22 of the Network Provider Development and Management Plan. The plan's Geo-Access reports reflect the adequate ratios of providers to members in Appendix UU.	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Accessibility to Care (P/P) LAGeo3Q16 Appendix UU			
7.5	**Monitoring and Reporting on Provider Networks**				
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Network Provider Development and Management Plan Provider Handbook Provider Network Accessibility Analysis Quarterly - LA Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) LAPEC-1132-16 Appointment Availability and After Hours Surveys- Instructions LAPEC-1131-16 BH Appointment Availability Survey Script	Full	This requirement is addressed on page 23 of the Network Provider Development and Management Plan. This requirement is addressed in the Provider Handbook on pages 17 and 18. The plan monitors appointment availability by using the Standards and Measures and Monitoring Appropriate Accessibility to Care Policy.	
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly LAGeo3Q16 documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly LAGeo3Q16 shall be consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide.	LAGeo3Q16 Q3 GeoAccess Attestation Q3 GeoAccess Cover letter Network Development and Management Plan	Full	The plan submitted the LAGeo3Q16 report which documents the geographic availability of network providers. The data in this report is consistent with the requirement and includes distance, population density, and provider availability variables. The plan submitted the Network Adequacy Attestation with the LAGeo3Q16 report. This attestation contains narrative language which identifies gaps in coverage and the corrective measures that will	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.			address them.	
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** Quarterly LAGeo3Q16 shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.	LAGeo3Q16 Network Development and Management Plan Email to DHH – Weekly Member Linkage Submission (Screenshots)	Full	This requirement is addressed in the Network Development and Management Plan on page 23 and in the plan's geo-access data found in the LAGeo3Q16 report.	
7.6	**Provider Enrollment**				
7.6.1 7.6.1.1	**Provider Participation -** The MCO must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs); all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services) and all providers approved by the DHH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.	Network Development and Management Plan Sample Hybrid Participating Provider Agreement OPH Contract OPH Amendment	Full	This requirement is addressed in the Network Development and Management Plan on page 23.	
7.6.1.1.1	The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH:	Network Development and Management Plan Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Network Development and Management Plan on page 23. The plan provided the Sample Hybrid Agreement as evidence of compliance.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Rural Health Clinics (RHCs); • Local Governing Entities; • Federally Qualified health Centers; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Mental Health Rehabilitation (MHR) Agencies; • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).	Behavioral Health Addendum Form		–	
7.6.1.2	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Network Development and Management Plan Sample Hybrid Participating Provider Agreement Sample Physician and AHP Participating Provider Agreement Sample Ancillary Participating Provider Agreement	Full	This requirement is addressed in the Network Development and Management Plan on page 23. The plan provided the Sample Hybrid Agreement as evidence of compliance.	
7.6.1.3	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached	Network Development and Management Plan Sample Hybrid Participating	Full	This requirement is addressed in the Network Development and Management Plan on page 23. The plan provided the Sample Hybrid	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Provider Agreement Sample Physician and AHP Participating Provider Agreement Sample Ancillary Participating Provider Agreement		Agreement, the Sample Physician and AHP Agreement and the Sample Ancillary Participating Provider Agreement as evidence of compliance.	
7.6.1.4	The provisions above (7.6.1.2 and 7.6.1.3) do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan on pages 23 and 24.	
7.6.1.5	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Network Development and Management Plan Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on pages 23 and 24. This requirement is also addressed in the Credentialing Policy.	
7.6.1.6	The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan on page 24.	
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at	Network Development and Management Plan Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P) Credentialing Program Integrity Sanction Review and	Full	This requirement is addressed in the Network Development and Management Plan on pages 24 and 25. This requirement is also addressed in the Credentialing Policy.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Monitoring			
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Network Development and Management Plan Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on page 24. This requirement is also addressed in the Credentialing Policy.	
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Network Development and Management Plan Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on page 24. This requirement is also addressed in the Credentialing Policy.	
7.6.3.3	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider. The MCO shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.	Network Development and Management Plan Credentialing and Re-credentialing for Licensed Independent Practitioners	Full	This requirement is addressed in the Network Development and Management Plan on page 24. This requirement is also addressed in the Credentialing Policy.	
7.6.3.4	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	Network Development and Management Plan Timely Notification of Participating Provider Termination – LA (P/P) Sample Member Letter – Provider Termination	Full	This requirement is addressed in the Network Development and Management Plan on page 24. This requirement is also addressed in the Timely Notification of Participating Provider Termination Policy.	
7.7	**Mainstreaming**				
7.7.1	DHH considers mainstreaming of MCO	Provider Handbook	Full	This requirement is addressed in	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.			the Provider Handbook on pages 18 and 60.	
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider Handbook Sample Physician and AHP Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on pages 18 and 48.	
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider Handbook Sample Physician and AHP Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 18.	
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Provider Handbook Sample Physician and AHP Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 18.	
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Provider Handbook Sample Physician and AHP Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 18.	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing	Provider Handbook Network Development and Management Plan	Full	This requirement is addressed in the Provider Handbook on page 60 and in the Network Development and Management Plan on page 25.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Provider Handbook Network Development and Management Plan	Full	This requirement is addressed in the Provider Handbook on page 60 and in the Network Development and Management Plan on page 25.	
7.8.2	**Primary Care Provider Responsibilities**				
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:				
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	Coordination of Care between Physical and Behavioral Health Providers Provider handbook Network Development and Management Plan	Full	This requirement is addressed in the Coordination of Care between Physical and Behavioral Health Providers Policy and in the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Handbook.	
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.10	Working with MCO case managers to develop	Network Development and	Full	This requirement is addressed on	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	plans of care for members receiving case management services.	Management Plan Provider handbook		page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	Network Development and Management Plan Provider Handbook	Full	This requirement is addressed on page 26 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook.	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	Provider Handbook Network Development and Management Plan	Full	This requirement is addressed on page 27 of the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Handbook on page 13.	
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.				
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	Network Development and Management Plan	Full	This requirement is addressed on page 29 of the Network Development and Management Plan.	
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	Network Development and Management Plan Provider Network Accessibility Analysis Quarterly (P/P)	Full	This requirement is addressed on page 31 of the Network Development and Management Plan.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	Provider Network Accessibility Analysis Quarterly (P/P) LAGeo3Q16	Full	This requirement is addressed on page 5 of the Network Development and Management Plan. Evidence of compliance with this requirement is found in the data of the LAGeo3Q16 report.	
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.	Provider Network Accessibility Analysis Quarterly (P/P) Standards and Measures Monitoring Appropriate Accessibility to Care (P/P)	Full	This requirement is addressed on page 1 of the Provider Network Accessibility Analysis Quarterly Policy and in the Standards and Measures Monitoring Appropriate Accessibility to Care Policy.	
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) Network Development and Management Plan	Full	This requirement is addressed on page 10 of the Provider Network Accessibility Analysis Quarterly Policy and in the Standards and Measures Monitoring Appropriate Accessibility to Care Policy.	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.				
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. MCO must establish access to the following within their network of hospitals: Level III Obstetrical services; Level III Neonatal	LAGeo3Q16 Network Development and Management Plan	Full	This requirement is addressed on page 30 of the Network Development and Management Plan and in the LAGeo3Q16 report.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.				
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	LAGeo3Q16 Network Development and Management Plan	Full	This requirement is addressed throughout the Network Development and Management Plan and in the LAGeo3Q16 report.	
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	LAGeo3Q16 Network Development and Management Plan	Full	This requirement is addressed throughout the Network Development and Management Plan and in the LAGeo3Q16 report.	
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	LAGeo3Q16 Network Development and Management Plan Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P)	Full	This requirement is addressed in the Network Development and Management Plan and in the LAGeo3Q16 report.	
7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	LAGeo3Q16 Network Development and Management Plan Standards and Measures & Monitoring Appropriate Accessibility to Care (P/P) Member Handbook – Integrated Health Services	Full	This requirement is addressed throughout the Network Development on and Management Plan on page 31 and in the LAGeo3Q16 report.	
7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services	Network Development and Management Plan	Full	This requirement is addressed throughout the Network Development on and Management Plan on page 31 and in the	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.	Member Handbook – Integrated Health Services		LAGeo3Q16 report.	
7.8.6.2	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.	Provider Handbook Member Handbook – Integrated Health Services	Full	This requirement is addressed on page 95 of the Provider Handbook and on page 19 of the Member Handbook.	
7.8.6.4	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	Provider Handbook	Full	This requirement is addressed on page 14 of the Provider Handbook.	
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide	Perinatal Services Policy	Full	This requirement is addressed in the Perinatal Services Policy.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.				
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Network Development and Management Plan	Full	This requirement is addressed on page 32 of the Network Development and Management Plan.	
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	Network Development and Management Plan	Full	This requirement is addressed on page 33 of the Network Development and Management Plan.	
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.				
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	Network Development and Management Plan	Full	This requirement is addressed on page 33 of the Network Development and Management Plan.	
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).	Network Development and Management Plan	Full	This requirement is addressed on page 33 of the Network Development and Management Plan.	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF	OPH Contract OPH Amendment	Full	This requirement is addressed in the OPH Contract and Amendment.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	(Medicaid), and the MCO.				
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall work with the existing network of behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	Network Development and Management Plan Access to Behavioral Health Care (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on pages 33 and 34 and in the Access to Behavioral Health Care on page 8.	
7.8.14.4	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing required peer services (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or CPST).	Network Development and Management Plan Access to Behavioral Health Care (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on pages 33 and 34 and in the Access to Behavioral Health Care on page 8.	
7.8.14.5	The MCO shall ensure that within the provider network, members enrolled in Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	Network Development and Management Plan Access to Behavioral Health Care (P/P)	Full	This requirement is addressed in the Network Development and Management Plan on page 40 and in the Access to Behavioral Health Care on page 8.	
7.8.14.7	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. The community- based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management	Network Development and Management Plan Behavioral Health Emergency Care	Full	This requirement is addressed in the Network Development and Management Plan on page 34 and in the Behavioral Health Emergency Care Policy.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and intervention, mobile crisis teams, and crisis stabilization in an alternative settings. If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.				
7.8.14.9	The MCO shall require behavioral health providers to screen for basic medical issues, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.	Network Development and Management Plan Behavioral Health Continuity and Coordination of Care	Full	This requirement is addressed in the Network Development and Management Plan on page 35 and in the Behavioral Health Continuity and Coordination of Care Policy on page 1 through 3.	
7.9	**Network Provider Development Management Plan**				
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider	Provider Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the following (42 CFR 438.206):				
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 4.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 4 and 5.	
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 5 through 7.	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 7.	
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 8 and 9.	
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 9 and 10.	
7.9.2.1	Assurance of Adequate Capacity and Services	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 10.	
7.9.2.2	Access to Primary Care Providers	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 10.	
7.9.2.3	Access to Specialists	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 10 and 11.	
7.9.2.4	Access to Hospitals	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 11.	
7.9.2.5	Access to Behavioral Health Services	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 11.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.9.2.6	Timely Access	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 11.	
7.9.2.7	Service Area	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 11.	
7.9.2.8	Other Access Requirements: Direct Access to Women's Health , Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 11 and 12.	
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included.	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 12 through 19.	
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.	Provider Network Development and Management Plan LAGeo3Q16	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19. The plans geo-access reports demonstrate network capacity.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:				
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19.	
7.9.5.2	Monitor network compliance with policies and rules of DHH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19.	
7.9.5.3	Evaluate the quality of services delivered by	Provider Network	Full	This requirement is addressed in	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the network;	Development and Management Plan		the Provider Network Development and Management Plan on page 19.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19.	
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	Provider Network Development and Management Plan Provider Network Accessibility Analysis Policy Standards and Measures & Monitoring Appropriate Accessibility to Care	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19.	
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 19.	
7.9.5.7	Provide training for its providers and maintain records of such training;	Provider Network Development and Management Plan Initial Training of Providers on Plan's Product (P/P)	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20. The plan provided the Initial Training of Providers Policy to show compliance with this requirement.	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20.	
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	resolved within 90 days.				
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20.	
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20.	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 35.	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 35 through 37.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 37 and 38.	
	• The numbers and types (in terms of training, experience, and specialization) of	Provider Network Development and	Full	This requirement is addressed in the Provider Network Development	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Management Plan BH GeoAccess Report		and Management Plan on page 38. This requirement is also addressed in the BH Geo-Access Report.	
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH quarterly by contract year, upon material change of the network, or upon request;	Provider Network Development and Management Plan BH GeoAccess Report	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 38. This requirement is also addressed in the BH Geo-Access Report.	

	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:
	  • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
	  • Specialized behavioral health service needs of members; and
	  • Growth trends in eligibility and enrollment, including:
	  ○ Current and anticipated numbers of Title XIX and Title XXI eligibles; and
	  ○ Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.
		Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 38.	

	• Accessibility of services, including: ○ The number of current qualified specialized behavioral health service	Provider Network Development and Management Plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 39	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; ○ The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; ○ Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and ○ Any service access standards detailed in a SPA or waiver.	Access to Behavioral Health Care		and in the Access to Behavioral Health Care Policy on pages 7 through 10.	
7.9.8.3	The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and provider profiling functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for arbitration data; and	Network development and management plan Evidence of submission of network development Plan to DHH- PI 053 Bayou Health Reporting AMG 2015 Reporting	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 39 and 40. The plan provided evidence of submission of the Network Development Plan to LDH as well as the Bayou Health Reporting email which shows evidence of receipt.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.				
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.	Network development and management plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 40 and 41.	
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: • Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for	Network development and management plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 40 and 41.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.				
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually.	Network development and management plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on pages 41 and 42.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.				
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network development and management plan	Full	This requirement is addressed in the Provider Network Development and Management Plan on page 20.	
7.11	**Material Change to Provider Network**				
7.11.1	The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 2.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.				
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 6.	
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 3.	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 3.	
7.11.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite the approval process.				
7.11.6	The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 3.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.				
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Timely Notification of Participating Provider Termination (P/P) Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 3.	
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not	Timely Notification of Participating Provider Termination (P/P) Network Development and Management Plan	Full	This requirement is addressed in the Timely Notification of Participating Provider Termination Policy on page 4 and in the Network Development Plan on pages 47 and 48.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	available as required by access standards approved by DHH.				
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan on pages 13, 14, 47, and 48.	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.	Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan on pages 47 and 48.	
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative	Timely Notification of Participating Provider Termination (P/P)	Full	This requirement is addressed on page 5 of the Timely Notification of Participating Provider Termination Policy.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	behavioral health service providers in accordance with the network notification requirements.				
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Timely Notification of Participating Provider Termination (P/P) HCM 2015 Program Evaluation Final Version UMC.MAC.QMC Termination of Provider Agreement Letters • Alternatives Living LLC Mandatory Terminations Alternatives Termination Letter	Full	This requirement is addressed on page 5 of the Timely Notification of Participating Provider Termination Policy. The plan submitted the Termination of Provider Agreement Letters as evidence of compliance with this requirement.	
7.12	**Coordination with Other Service Providers**				
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Network Development and Management Plan	Full	This requirement is addressed in the Network Development and Management Plan on paged 28, 29, and 46.	
7.13	**Provider Subcontract Requirements**				
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Credentialing and Recredentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 33.	
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Substantial	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 1 and 5. During file review onsite, one of the 10 credential files reviewed was missing the DEA or CDS certificate but it appears that the standard was checked. The other nine files contained all of the required documentation so the omission was not due to a systematic problem. In its response to the draft report, Amerigroup Louisiana, Inc. noted that only one file was missing the DEA/CDS certificate and this was due to an oversight. No systematic issue was observed and no change in procedure I required. The review determination is unchanged.	The health plan follows the requirements of NCQA section CR 3. Amerigroup Louisiana, Inc. utilizes the NTIS database and/or generates copies of the CDS from the Louisiana Board of Pharmacy for files presented. The document was inadvertently missing from the file. As noted by the reviewer, all files, including the file in question, had the standard checked.
7.14.1.1	Prior to subcontracting, the MCO shall follow DHH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 1 and 5.	
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 10 and 48.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	available for their provider type.				
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 48.	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	Copy of certificate Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49. The plan provided a copy of its NCQA certificate.	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. “Completely process” shall mean that the MCO shall:	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49.	
7.14.5.2	Submit on the weekly electronic Provider Directory to DHH or DHH’s designee; or	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49.	
7.14..6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 49 and 50.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	professionals are credentialed in accordance with DHH's credentialing requirements.				
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 50.	
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 50.	
7.14.9	The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 49.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on page 5.	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	Credentialing and Re-credentialing for Licensed Independent Practitioners (P/P)	Full	This requirement is addressed in the Credentialing and Recredentialing Policy on pages 26 and 27.	
7.14.12	The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	Reporting Authority and Requirements (P/P)	Full	This requirement is addressed on pages 1 through 6 of the Reporting Authority and Requirements Policy.	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with	Credentialing and Re-credentialing for Licensed	Full	This requirement is addressed on pages 35 and 36 of the	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	Independent Practitioners (P/P) Provider Discipline and Credentialing appeal Rights (P/P)		Credentialing and Recredentialing Policy and in the Provider Discipline and Credentialing Appeal Rights Policy.	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.				
7.16	**Provider-Member Communication Anti-Gag Clause**				
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	Provider Handbook Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Provider Handbook Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	Provider Handbook Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Provider Handbook Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment	Provider Handbook Sample Hybrid Participating Provider Agreement	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	decisions.				
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.				
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Provider Handbook Sample Hybrid Participating Provider Agreement Member Handbook – Integrated Health Services	Full	This requirement is addressed in the Provider Handbook on page 26 and in the Sample Hybrid Agreement.	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
8.1	**General Requirements**				
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	UM Program Description Clinical Information for Utilization Management Reviews – Core Process – LA Policy and Procedure Reviews Q3 MPTAC Notification LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL 8.1 LA CPG Matrix	Full	Documented in UM Program Description. InterQual is used for UR decisions.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:				
8.1.2.1	Are adopted in consultation with contracting health care professionals;	Q3 MPTAC Notification LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL	Full	Documented in LA CAID MPUM Guidelines and Post MPTAC 2016 summaries	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	Q3 MPTAC Notification LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL	Full	Documented by use of clinical guidelines (InterQual) and Medical policies	
8.1.2.3	Are considerate of the needs of the members; and	Clinical Criteria for Utilization Management Decisions - Core Process UM Program Description LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL	Full	Documented in Program Description (p.7) where members with complex and exceptional needs are considered. Also noted in Clinical Criteria for UR Management Decisions	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	Policy and Procedure Reviews Clinical Criteria for Utilization Management Decisions - Core Process UM PROGRAM DESCRIPTION Q3 MPTAC Notification LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY	Full	Annual timeframe is documented in Policy and Procedure reviews document (p7)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL			
8.1.3	The policies and procedures shall include, but not be limited to:				
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	Clinical Criteria for Utilization Management Decisions - Core Process Utilization Management Clinicians Responsibilities UM PROGRAM DESCRIPTION Q3 MPTAC Notification LA CAID MPUM GUIDELINES MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL	Full	Documented in UM Program Description (Objectives section)	
8.1.3.2	The data sources and clinical review criteria used in decision making;	Clinical Information for Utilization Management Reviews – Core Process - LA Clinical Criteria for Utilization Management Decisions - Core Process UM PROGRAM DESCRIPTION Q3 MPTAC Notification LA CAID MPUM GUIDELINES	Full	Documented in Clinical Criteria for Utilization Management Decisions - Core Process UniCare and UniCare Behavioral Health guidelines are used,)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		MCG PROVIDER SUMMARY POST MPTAC Q3 2016 FINAL POST MPTAC Q2 2016 FINAL POST MPTAC Q1 2016 FINAL POST MPTAC Q1 2015 FINAL			
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Utilization Management Clinicians Responsibilities (Health Plan/Region)	Full	Documented in Utilization Management Clinicians Responsibilities (p2)	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Peer to Peer Policy	Full	Informal Consideration process is documented in the plan's Peer to Peer Policy	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Clinical Criteria for Utilization Management Decisions - Core Process Inter-Rater Reliability (IRR) Assessments UM PROGRAM Description	Full	Documented in Clinical Criteria for Utilization Management Decisions - Core Processes (p1)	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	Clinical Criteria for Utilization Management Decisions - Core Process	Full	Documented in Clinical Criteria for Utilization Management Decisions - Core Processes (p4)	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	Clinical Information for Utilization Management Reviews – Core Process - LA Utilization Management Clinicians Responsibilities	Full	Documented in Clinical Information for Utilization Management Reviews – Core Process – LA (p5) and Utilization Management Clinicians Responsibilities (p2)	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	Clinical Information for Utilization Management Reviews – Core Process – LA specifies authorization policy for Inpatient Psychiatric hospitals Criteria for other types of services are documented in the Community Psychiatric and Treatment (CPST) Guideline that was submitted onsite.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	POLICY: Louisiana Office of Juvenile Justice (OJJ) & Other Child-Serving Agencies: Department of Health and Hospitals, Department of Child And Family Services, Office of Citizens With Development Disabilities, and Department of Education-LA	Full	Documented in the plan's: POLICY: Louisiana Office of Juvenile Justice (OJJ) & Other Child-Serving Agencies	
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	Behavioral Health Stabilization/Discharge Planning Process	Full	Process is documented in the plan's: Behavioral Health Stabilization/Discharge Planning Process	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	Behavioral Health Stabilization/Discharge Planning Process	Full	Process is documented in the plan's: Behavioral Health Stabilization/Discharge Planning Process	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	Behavioral Health Stabilization/Discharge Planning Process	Full	Process is documented in the plan's: Behavioral Health Stabilization/Discharge Planning Process	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Physician's Order for PDHC PDHC Prior Authorization checklist LALA_CAID_Pediatric Day Policy LALA_39-Week initiative Below39weeksworksheet LALA_CAID_NOP	Full	Several Guidelines have been developed in collaboration with other MCOs in the state, including a Physicians order for PDHC, a Pediatric policy and a 39 week maternity initiative	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		LALA_SBIRT-FLYER			
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Provider Education and Communication Clinical Practice Guidelines Member Handbook	Full	Evidence that practice guidelines are made available to providers was found in Provider Education and Communication Policy. It is also available in the UM denial letter to members and on the plan's open website. Recommendation: This information should be added to the Member Handbook on p 64. In its response to the draft report, Amerigroup submitted a revised Member Handbook to reflect the additional language.	Member Handbook; Grievances and Medical Appeals, Printed page # 65
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	Clinical Practice Guidelines Medical and Treatment Record Review - LA Provider Handbook	Full	The Medical and Treatment Record Review - LA policy provides a detailed description of the process used to measure provider compliance. The thresholds for compliance (90% or more providers and at least 80% compliance can be found in the plan's VBP policy provided onsite and in the plan's Medical and treatment Record Review – LA policy, also provided onsite.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	Clinical Criteria for Utilization Management Decisions - Core Process Provider Handbook	Full	Criteria is documented in the plan's Clinical Criteria for Utilization Management Decisions - Core Process	
8.1.6.1	The vendor must be identified if the criteria was purchased;	Clinical Criteria for Utilization Management Decisions - Core Process Provider Handbook	Full	Vendors are documented in the plan's Clinical Criteria for Utilization Management Decisions - Core Process	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care	Clinical Criteria for Utilization Management Decisions - Core Process	Full	Associations are documented in the plan's Clinical Criteria for Utilization Management Decisions - Core	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	provider association or society;	Provider Handbook		Process	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Clinical Criteria for Utilization Management Decisions - Core Process Provider Handbook	Full	Source is identified in the plan's Clinical Criteria for Utilization Management Decisions - Core Process	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA	Full	Reviewer credentials are outlined in the plan's Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA	
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process – LA Provider Handbook	Full	The plan's Concurrent Review policy includes criteria for use of practice guidelines. Provider Manual informs providers of Amerigroup's UM policies. The information is provided in the Member Handbook (p 62)	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	Written procedures are detailed in UM Reviews – Core Process P/P, The Procedure Section. It is also included in the UM denial letter as Peer to peer review and in the member Handbook (p 62).	
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	Clinical Information for Utilization Management Reviews – Core Process – LA Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA	Substantial	Written procedures to address the failure to provide the necessary information for review are detailed in the plan's Concurrent review policy. However, the plan does not specify the timeframe for denying the authorization or whether the plan has a defined timeframe. According to the regulations, "the MCO may deny authorization of the requested service(s) within two (2) business	Concurrent Review (Telephonic and On-site) and On-Site Review Protocol Process – LA; Page 7 - 8; Procedures – Insufficient Clinical Information Language added to reflect MCO may deny auth of requested services within two business days. Clinical Information for Utilization Management Reviews – Core Process – LA; Page 7; Insufficient Clinical

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				days." In its response to the draft report, Amerigroup Louisiana, Inc. submitted revised policies to reflect the additional language. Review determination is unchanged since the revisions were made after the review period.	Information Added: "The MCO may deny authorization of the requested service(s) within two (2) business days in cases where the provider or member will not release necessary information."
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: Specialized behavioral health services, and PSH to ensure appropriate authorization of tenancy services.	Utilization Management Clinicians Responsibilities	Full	The plan's Utilization Management Clinicians Responsibilities includes this regulation as part of an exception for Louisiana.	
8.1.11	The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes the DHH's medical necessity definition as defined in LAC 50:I.1101	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes this regulation (p2)	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes this regulation (p2)	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes this regulation (p2)	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes this regulation (p2)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.				
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA	Full	The plan's Concurrent Review policy includes this regulation (p2	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	Clinical Criteria for Utilization Management Decisions - Core Process Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA	Full	A mechanism to reduce inappropriate and duplicative use of health care services and the statement that services must be sufficient is included in the plan's Concurrent Review policy (p3)	
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations Member Handbook Policy – Prohibiting the Use of Financial Incentives When making Medical Necessity Determinations	Full	The regulation that compensation to individuals or entities that conduct UM activities is not structured to provide incentives is included in the plan's Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations policy	
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent	Concurrent Review (Telephonic and On-Site) and	Full	The definition of concurrent review is included in the plan's Concurrent	Concurrent Review (Telephonic and On-Site) and On-site Review

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization and post authorization.	On-site Review Protocol Process – Core Process - LA		Review policy. Recommendation: It is suggested that an additional definition for "Service Authorization" be included to avoid confusion. In its response to the draft report, Amerigroup submitted a revised policy to reflect the additional language.	Protocol Process – Core Process – LA; Definitions; Page 7
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert and Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:	Prior Authorization Liaison (PAL) Policy - LA	Full	The plan's Prior Authorization Liaison (PAL) Policy - LA details that the UM program conforms to state laws and the Chisholm cases	
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	Prior Authorization Liaison (PAL) Policy - LA	Full	The plan's Prior Authorization Liaison (PAL) Policy – LA includes this regulation (p4)	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Clinical Criteria for Utilization Management Decisions - Core Process Inter-Rater Reliability (IRR) Assessments UM PROGRAM Description	Full	The UM Program description and its Inter-Rater Reliability (IRR) Assessments policy details the steps the plan takes to ensure that reviews are conducted in a consistent manner.	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	Pre-Certification of Requested Services - LA	Full	The requirement that any decision to deny a service authorization request is made by a health care professional is stated in the plan's Pre-Certification of Requested Services – LA Policy (p2)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	Pre-Certification of Requested Services – LA Member Handbook	Full	The plan includes in its member Handbook a detailed Grievance and Appeals process but and does inform members of their right to submit a service authorization request in the Appeals section. Recommendation: It might be helpful to include this information in the Grievance Section of the Member Handbook. In its response to the draft report, Amerigroup submitted a revised Member Handbook to reflect the additional language	Member Handbook; Grievances and Appeals section; printed page 55 – added language: "You can also call or submit in writing a request for authorization of service."
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	Pre-Certification of Requested Services - LA	Full	The Pre-Certification of Requested Services – LA policy makes provision for the authorization number and effective dates for authorization	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	Pre-Certification of Requested Services - LA	Full	The Pre-Certification of Requested Services – LA policy makes provision for storing the information electronically	
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	Pre-Certification of Requested Services - LA	Full	The Pre-Certification of Requested Services – LA policy makes provision for not denying continuation or higher levels of service	
8.4.4	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	The plan's Clinical Information for Utilization Management Reviews – Core Process – LA (p4) includes language regarding admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.4.4.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	The plan's Clinical Information for Utilization Management Reviews – Core Process – LA (p4) includes language regarding that inpatient psychiatric hospital and utilization reviews should be completed by an LMHP	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	The plan's Clinical Information for Utilization Management Reviews – Core Process – LA (p 5) includes language regarding that UR should not be reported to DHH in encounter data and that these reviews are not considered prior authorizations	
8.4.4.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	The plan's Clinical Information for Utilization Management Reviews – Core Process – LA (p 5), specific for Louisiana, includes this language in its entirety (p6-8)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual				

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.				
8.4.4.4	Certification of Need for PRTFs				
8.4.4.4.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.				
8.4.4.4.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	Clinical Criteria for Utilization Management Decisions - Core Process	Full	The plan's Clinical Criteria for Utilization Management Decisions - Core Process includes requirement that LMHPs are included on the team responsible for certification and recertification.	
8.4.4.4.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	Clinical Criteria for Utilization Management Decisions - Core Process	Full	The plan's Clinical Criteria for Utilization Management Decisions - Core Process includes the language required in the regulation (p15-16)	
8.4.4.4.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	Clinical Criteria for Utilization Management Decisions - Core Process	Full	The plan's Clinical Criteria for Utilization Management Decisions - Core Process includes the language required in the regulation (p15-16)	
8.4.4.4.5	In addition to certifying the need, the MCO shall: Be responsible for tracking the member's authorization period for PRTF stays and	Clinical Criteria for Utilization Management Decisions - Core Process	Full	The plan's Clinical Criteria for Utilization Management Decisions - Core Process includes the language required in the regulation (p15-16)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	providing notification to the responsible party when a recertification is due. Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility. Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal, and the process to do so. Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.				
8.4.5	At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.	Clinical Criteria for Utilization Management Decisions - Core Process	Full	The plan's Clinical Criteria for Utilization Management Decisions - Core Process includes the language required in the regulation (p15-16)	
8.5	**Timing Of Service Authorization Decisions**				
8.5.1	**Standard Service Authorization**				
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information	Clinical Information for Utilization Management Reviews – Core Process - LA	Full	The Clinical Information for Utilization Management Reviews – Core Process - LA policy contains the language regarding eighty	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	Pre-Certification of Requested Services – LA UM Program Description		percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service.	
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	Clinical Information for Utilization Management Reviews – Core Process – LA UM Program Description	Full	The Clinical Information for Utilization Management Reviews – Core Process - LA policy contains the language regarding the timeliness standards	
8.5.2	**Expedited Service Authorization**				
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	Clinical Information for Utilization Management Reviews – Core Process - LA Pre-Certification of Requested Services – LA UM Program Description	Full	The Clinical Information for Utilization Management Reviews – Core Process - LA policy contains the language regarding the service authorization expedited timeframe. (p7-8)	
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.	Clinical Information for Utilization Management Reviews – Core Process - LA Pre-Certification of Requested Services – LA UM Program Description	Full	The Clinical Information for Utilization Management Reviews – Core Process - LA policy contains the language regarding the time extension requirement.	
8.5.3	**Post Authorization**				
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Clinical Information for Utilization Management Reviews – Core Process – LA Pre-Certification of Requested Services – LA UM Program Description	Full	The Clinical Information for Utilization Management Reviews – Core Process - LA policy contains the language regarding the timeliness standard (p 9)	
8.5.3.2	The MCO shall not subsequently retract its	Clinical Information for	Full	The Clinical Information for	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Utilization Management Reviews – Core Process - LA Pre-Certification of Requested Services – LA UM Program Description		Utilization Management Reviews – Core Process - LA policy contains the language regarding the requirement that delineates the circumstances under which the plan cannot retract its authorization (p 12)	
8.5.4	**Timing of Notice**				
8.5.4.1	**Notice of Action**				
8.5.4.1.1	**Approval [Notice of Action]**				
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Pre-Certification of Requested Services – LA	Full	The plan's Pre-Certification of Requested Services – LA policy includes the service authorization approval timing regulation (p 6)	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Pre-Certification of Requested Services – LA	Full	The plan's Pre-Certification of Requested Services – LA policy includes the service authorization approval timing regulation (p 6)	
8.5..4.1.2	**Adverse [Notice of Action]**				
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	Pre-Certification of Requested Services – LA HCMS Denial - Core Policy	Full	The plan's Pre-Certification of Requested Services – LA policy includes the content of the denial notification to a member (p 7)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Pre-Certification of Requested Services – LA Health Care Management Denial Core Process	Full	The plan's Pre-Certification of Requested Services – LA policy includes the content of the denial notification to a provider and includes the timeliness requirement (p 7)	
8.5.4.1.3	**Informal Reconsideration**				
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Health Care Management Denial Core Process Provider Handbook	Full	The Provider Handbook details the Informal Reconsideration process and is included in the Member Handbook. as Peer to Peer Review	
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	Health Care Management Denial Core Process Provider Handbook	Full	The Provider Handbook details the Informal Reconsideration process and is included in the Member Handbook as Peer to Peer Review.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	Health Care Management Denial Core Process Provider Handbook	Full	The timeliness standard is indicated in the Provider Manual	
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	Health Care Management Denial Core Process	Full	The 30 day timeframe is indicated in the Health Care Management Denial	**Peer to Peer; Policy, Page 1; Procedure Page 4**

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Provider Handbook		Core Process policy Recommendation: It may be helpful to prepare a new P/P on Informal Reconsiderations or peer to Peer Review that would include the contract requirements and indicate how members and providers will be notified. In its response to the draft report, Amerigroup submitted a revised Peer to Peer to reflect the additional language	
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description Provider Handbook	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p14)	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description Provider Handbook Provider Quick Reference Card (LALA _QRC)	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p14)	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description Provider Handbook	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p14)	
8.5.4.2	The MCO shall not require service authorization for the continuation of	Concurrent Review (Telephonic and On-Site) and	Full	The regulation is stated in the plan's Concurrent Review	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.	On-Site Review Protocol Process UM Program Description		(Telephonic and On-Site) and On-Site Review Protocol Process (p 15)	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p15)	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p15)	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p15)	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description Provider Handbook	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p15)	
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p15)	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process UM Program Description	Full	The regulation is stated in the plan's Concurrent Review (Telephonic and On-Site) and On-Site Review Protocol Process (p16)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.11	**Medical History Information**				
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.	Pre-Certification of Requested Services – LA Provider Handbook	Full	The regulation is stated in the plan's Pre-Certification of Requested Services – LA. (p 5). Providers are informed of the regulation and process in the provider Handbook (p81)	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	Pre-Certification of Requested Services – LA Provider Handbook	Full	Providers are informed of the regulation and process in the provider Handbook (p81)	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Pre-Certification of Requested Services – LA Provider Handbook	Full	Providers are informed of the regulation and process in the provider Handbook (p81	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	Pre-Certification of Requested Services – LA Provider Handbook	Full	Providers are informed of the regulation and process in the provider Handbook (p81). Recommendation: Rather than including the regulation in the pre-Certification of requested Services where it is not explicitly explained, the plan should consider including the requirements in the plan's Medical and Treatment Record Review – LA policy. In its response to the draft report, Amerigroup submitted a revised policy to reflect the additional language	Medical and Treatment Record Review – LA; Procedure # 6; Page 3 – added language of the requirement
8.12	**PCP And Behavioral Health Provider Utilization And Quality Profiling**				
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	Provider Network Accessibility Analysis Quarterly — LA	Full	Profiling policy and procedure is stated in the plan's Provider Network Accessibility Analysis Quarterly — LA The plan explained onsite that the	E-mail from LDH provided documenting LDH decision to archive Report # 72

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				state requirement to submit a PCP profiling report was discontinued. The plan does profile its BH providers via a quarterly report. In its response to the draft report, Amerigroup provided an email from LDH documenting the decision to discontinue.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Provider Network Accessibility Analysis Quarterly — LA Quality of Care - Core Procedure	Full	The regulation is included in the plan's Provider Network Accessibility Analysis Quarterly — LA The plan produces an Adverse Incident report to document utilization and quality of care issues.	
8.12.3	The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall include, but are not limited to, the following:	Provider Network Accessibility Analysis Quarterly — LA	Full	As explained onsite, a quarterly BH report is prepared and submitted to the LDH quarterly. The requirement to submit a PCP report has been discontinued. In its response to the draft report, Amerigroup provided an email from LDH documenting the decision to discontinue	E-mail from LDH provided documenting LDH decision to archive Report # 72
8.12.3.1	Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	Provider Network Accessibility Analysis Quarterly — LA	Full	The regulation is stated in the document "Provider Network Accessibility Analysis, the plan indicated it would provide a report of its out-of-network utilization in follow-up to the onsite visit. In its response to the draft report, Amerigroup provided An Out of Network report (OON) as evidence of outreach efforts. Review determination has been revised to fully compliant.	OON Report Q4 2016 Page 18 of the Provider Manual states: "As a specialist, you will treat members who are: Referred by network PCPs Self – referred Note that PCP referral is not required, but it is encouraged to ensure coordination of care. *All* OON services require authorization and, as such, the Health Plan can gauge out of network (OON) utilization using the OON report as evidence of efforts. The Health Plan can see the utilization by OON providers

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					and proactively outreach any provider that we identify as a potential impact to our population or network.
8.12.3.2	Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	Specialty Referral Policy	Full	The regulation is detailed in the plan's Specialty Referral Policy (p 4)	
8.12.3.3	Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;	Behavioral Health Emergency Care	Full	The regulation is detailed in the plan's Behavioral Health Emergency Care (p 6)	
8.12.3.4	Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	Provider Network Accessibility Analysis Quarterly — LA	Full	Hospital admits, lab services, medications, and radiology services appear in the plan's Provider Network Accessibility Analysis Quarterly — LA	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	Provider Network Accessibility Analysis Quarterly — LA	Full	Outcome monitoring is detailed in the plan's Provider Network Accessibility Analysis Quarterly — LA (p3 and 6)	
8.13	**PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements**				
8.13.0	The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	n/a state retired this report. see "memo email" (Retired Report)	N/A	Additional LDH reports were not required.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11	**Disenrollment**				
11.11.1	Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the Bayou Health Program.				
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA In the Procedure, Page 1.	
11.11.3	**Member Initiated Disenrollment**				
11.11.3.1	A member may request disenrollment from a MCO as follows: For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member requests to be assigned to the same MCO as family members; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and DHH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; • The member's active specialized behavioral health provider ceases to contract with the MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by DHH and/or its agent.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA ins the Procedure: Enrollee-Initiated Disenrollment, page 1-2	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).	Disenrollment - LA	Full	This requirement is met through document: Disenrollment- LA In the Procedure: Without Cause, page 2	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA in the Procedure, page 2	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment- LA in the procedure, page 2	
11.11.4	**MCO Initiated Disenrollment**				
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).	Disenrollment - LA LA MEM 0329 15 LA Involuntary Disenrollment Request	Full	This requirement is met through document: Disenrollment-LA in the procedure: MCO Initiated Disenrollment, Letter, page 3. Also through LA MEM 0329 15 LA Involuntary Disenrollment Request, page 1	
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP.	Disenrollment - LA	Full	This requirement is met through document:	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	(See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.			Disenrollment-LA in the procedure: MCO Initiated Disenrollment, page 3	
11.11.4.3	The following is the only allowable reason for which the MCO may request involuntary disenrollment of a member: the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH;	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA in the Procedure: MCO Initiated Disenrollment, page 3	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	Disenrollment – LA LA MEM 0329 15 LA Involuntary Disenrollment Request	Full	This requirement is met through document: Disenrollment-LA in the Procedure: MCO Initiated Disenrollment, page 3 Also through LA MEM 0329 15 LA Involuntary Disenrollment Request, page 1	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	Disenrollment - LA	Full	This requirement is partially met through the document: Disenrollment – LA. The MCO should update their Disenrollment form to include a place for a detailed reason for requesting the disenrollment, and for a description of the measures taken to correct member behavior prior to requesting disenrollment to reflect the required language of the contract. In its response to the draft report, Amerigroup stated that it utilizes the state required template to report for disenrollments. Since the from cannot be modified by MCOs, the review determination has been revised to "fully compliant"	• Appendix T • Appendix U (Disenrollment Form) • LA-MEM-0329-15 LA Inv Dis Rqust Ltr LDH provides the Request for Member Disenrollment template letter (attached) and cannot be revised by an individual MCO. The Request for Member Disenrollment Letter is Appendix T of the current LDH state contract. Per the LDH state contract, MCOs are only allowed to disenroll per the following reasons: 11.11.4.3. The following is the only allowable reason for which the MCO may request

Eligibility, Enrollment and Disenrollment					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					involuntary disenrollment of a member: The member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to LDH. The form does include an "Other" line to provide additional information if the request for involuntary disenrollment does not fit the provided explanations.
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA In the Procedure: MCO Initiated Disenrollment, page 4	
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA In the Procedure: MCO Initiated Disenrollment, page 5	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.				
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	Disenrollment - LA	Full	This requirement is met through document: Disenrollment-LA In the Procedure: MCO Initiated Disenrollment, page 5	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**				
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):				
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: Flesch – Kincaid; Fry Readability Index; PROSE The Readability Analyst (software developed by Educational Activities, Inc.); Gunning FOG Index; McLaughlin SMOG Index; or other computer generated readability indices accepted by DHH.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 1 Member Handbook: Integrated Health Services, title page	
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 1 Member Handbook: Integrated Health Services	
12.9.3	DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Handbook: Integrated Health Services	
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	Member Written Materials Guidelines – LA	Full	This requirement is met through the document: Member Written Materials Guidelines – LA, pages 1 and 3	
12.9.5	All written materials must be in accordance with the DHH “Person First” Policy, Appendix NN.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 1 Member Handbook: Integrated	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		LAMKT 0250 16 LA Transportation Full Flier LA MEM 0266 LA BH Benefit Change Letter		Health Services, page 2 LAMKT 0250 16 LA Transportation Full Flier LA MEM 0266 LA BH Benefit Change Letter	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	Not Applicable – do not have a commercial plan in state	N/A	NA – no commercial plan in Louisiana	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 1 Member Handbook: Integrated Health Services, title page	
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	Member Written Materials Guidelines – LA Oral Translation Interpretation Services Requests for Translations and Alternate Formats of Member Communications	Full	This requirement is met through the documents: Oral Translation Interpretation Services Requests for Translations and Alternate Formats of Member Communications	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	Member Written Materials Guidelines – LA Member Handbook: Integrated Health Services	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 2 Member Handbook: Integrated Health Services, page 8	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	Member Written Materials Guidelines – LA Requests for Translations and Alternate Formats of Member Communications	Full	This requirement is met through the documents: Member Written Materials Guidelines – LA, page 2 Requests for Translations and Alternate Formats of Member Communications, page 2	
12.11	**Member Education – Required Materials and**				

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Services				
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	Member Written Materials Guidelines – LA	Full	This requirement is met through the document: Member Written Materials Guidelines-LA, page 1 procedure 6	
12.11.3	**Member Materials and Programs for Current Enrollees**				
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Public - https://www.myamerigroup.com/la/Pages/welcome.aspx Secure - https://www.myamerigroup.com/Pages/Login.aspx	Full	This requirement is met through the documents: Public - https://www.myamerigroup.com/la/Pages/welcome.aspx Secure - https://www.myamerigroup.com/Pages/Login.aspx	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	LALA CAID Newsletter Q1 2016	Full	This requirement is met through the document: LALA CAID Newsletter Q1 2016	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Member Handbook: Integrated Health Services LAAT Growth & Development PHL	Full	This requirement is met through the documents: Member Handbook: Integrated Health Services, intro, pages 44-47 LAAT Growth & Development PHL	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	LAAT CAD 011 LAAT DIA2	Full	This requirement is met through the documents: LAAT CAD 011 LAAT DIA2	
12.11.3.5	Materials focused on health promotion programs available to the members;	LaPEC 1089 LA Sickle Cell HLA C 0009 16 LA Sickle Cell Dis Flr	Full	This requirement is met through the documents: LaPEC 1089 LA Sickle Cell HLA C 0009 16 LA Sickle Cell Dis Flr	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 44-47, 52	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 52	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	RE2 LAAT RSV PCHL LAAT HIV 0111 LA01802 Final Letter AmeriTips By Target Audience and Event Type	Full	This requirement is met through the documents: RE2 LAAT RSV PCHL LAAT HIV 0111 LA01802 Final Letter AmeriTips By Target Audience and Event Type	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Member Handbook: Integrated Health Services LAMEM041516 LA HCMS Coordination of Care Welcome Letter Diabetes Lunch and Learn Announcement LA01802 Final Letter AmeriTips By Target Audience and Event Type	Full	This requirement is met through the documents: Member Handbook: Integrated Health Services, page 44 LAMEM041516 LA HCMS Coordination of Care Welcome Letter, page 1 Diabetes Lunch and Learn Announcement LA01802 Final Letter AmeriTips By Target Audience and Event Type	
12.11.3.11	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	LA MEM 0266 LA BH Benefit Change Letter	Full	This requirement is met through the document: LA MEM 0266 LA BH Benefit Change Letter, page 1	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by DHH for	Member Written Materials Guidelines – LA	Full	This requirement is met through the document:	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	these materials and/or programs.			Member Written Materials Guidelines – LA, page 3	
12.12	**MCO Member Handbook**				
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (f)(6) for each of the covered populations as specified in section 3.3.3.)..	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services	
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:				
12.12.1.2	Table of contents;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, Table of contents	
12.12.1.3	A general description about how MCOs operate, member rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 1-15 and 42-43	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 66	
12.12.1.5	Member's right to change providers within the MCO;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 9	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 9	
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 62-66	
12.12.1.8	The amount, duration, and scope of benefits	Member Handbook:	Full	This requirement is met through the	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	Integrated Health Services		document: Member Handbook: Integrated Health Services, ages 16-29 and 33-35	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 40	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 7-8	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 9,11,8,2,15,19,31,32,33,40,44-77, 48-49	
12.12.1.12	The extent to which, and how, after-hours , crisis and emergency coverage are provided, including: What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); That prior authorization is not required for emergency services; The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 40, 42-43	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	other setting for emergency care.				
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 24, 43, 64	
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 11	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 39	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page63 and 50	
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 63	
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 55-59	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: For State Fair Hearing: the right to a hearing; the method for obtaining a hearing; and the rules that govern representation at the hearing; The right to file grievances and appeals; The requirements and timeframes for filing a grievance or appeal; The availability of assistance in the filing process; The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 55-59	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	The fact that, when requested by the member: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.				
12.12.1.20	Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of advance directives which shall include: The MCO policies related to advance directives; The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 54-55, and page 61 Also through the Behavioral Health Member Handbook, page 36 and 37.	
12.12.1.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services The website for this element has been updated by LDH	
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than	Member Handbook: Integrated Health Services	Full	This requirement is met through the document:	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	being a "no show";			Member Handbook: Integrated Health Services, pages 12-14	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 2-3	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 6 and 14	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 17 and pages 44-46	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 61	
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 61	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 65-66	
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, Intro and page 3, 5, 645	
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR	Member Handbook: Integrated Health Services	Full	This requirement is met through the document:	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	§438.206(b)(3) at no cost and how to obtain it;			Member Handbook: Integrated Health Services, page 9	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 66	
12.12.1.32	Any additional text provided to the MCO by DHH or deemed essential by the MCO;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 61-62	
12.12.1.33	The date of the last revision;	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, bottom right hand corner of each page.	
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.6(h)]. Service utilization policies; and How to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, page 66.	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: A description of covered behavioral health services; Where and how to access behavioral health services and behavioral health providers; General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and Any limitations involving the provision of information for adult persons who do not	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services, pages 4,31-32, 33-35, 3-39 and page 53	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.				
12.12.1.36	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	LALA_CAID_Newsletter_Q1_2016 Member Handbook: Integrated Health Services,	Full	This requirement is met through the documents: LALA_CAID_Newsletter_Q1_2016, green section Member Handbook: Integrated Health Services, intro letter	
12.12.1.37	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members.	Member Handbook: Integrated Health Services	Full	This requirement is met through the document: Member Handbook: Integrated Health Services	
12.14	**Provider Directory for Members**				
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (hard copy, full version) Louisiana Behavioral Health Provider Directory (hard copy, full version) Find a Doctor - Amerigroup Louisiana Member Website (screenshots) Louisiana Provider Directory (electronic file; PDF) Louisiana Behavioral Health Provider Directory (electronic file; PDF) Louisiana Provider Directory (hard copy, abbreviated version) Louisiana Behavioral Health	Full	This requirement is met through the document: Provider Directories (P/P), page 3 Louisiana Behavioral Health Provider Directory (hard copy, full version) Was unable to locate any of the other documents listed.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Provider Directory (hard copy, abbreviated version)			
12.14.1.1	A hard copy directory, when requested, for members and potential members;	Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (hard copy, full version) Louisiana Behavioral Health Provider Directory (hard copy, full versions)	Full	This requirement is met through the documents: Provider Directories (P/P), page 3	
12.14.1.2	Web-based, searchable, online directory for members and the public;	Provider Directories (P/P) Find a Doctor - Amerigroup Louisiana Member Website (Screenshots)	Full	This requirement is met through the documents: Provider Directories (P/P), page 3 Find a Doctor - Amerigroup Louisiana Member Website (Screenshots)	
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and	Weekly Provider Updates 1 Weekly Provider Updates 2 Weekly Provider Updates 3 Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (electronic file; PDF) Louisiana Behavioral Health Provider Directory (electronic file; PDF)	Full	This requirement is met through the documents: Provider Directories (P/P), page 3 Weekly Provider Updates 1 Weekly Provider Updates 2 Weekly Provider Updates 3 Provider Directories: Louisiana Provider Directory (electronic file; PDF) Louisiana Behavioral Health Provider Directory (electronic file; PDF)	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (hard copy, abbreviated version) Louisiana Behavioral Health Provider Directory (hard copy, abbreviated version)	Full	This requirement is met through the documents: Provider Directories (P/P), page 3 Louisiana Behavioral Health Provider Directory (hard copy, abbreviated version)	
12.14.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly to fulfill requests by	Provider Directories (P/P)	Full	This requirement is met through the document: Provider Directories (P/P), pages 3-	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by DHH.			4. The MCO stated they are providing the full directory when requested.	
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:				
12.14.4.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;	Provider Directories (P/P) Louisiana Provider Directory (hard copy, full version) Louisiana Provider Directory (electronic file; PDF) Find a Doctor - Amerigroup Louisiana Member Website (screenshots)	Full	This requirement is met through the document: Provider Directories (P/P), page 4 Unable to locate the other documents listed	
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (hard copy, full version) Louisiana Behavioral Health Provider Directory (hard copy, full version) Find a Doctor - Amerigroup Louisiana Member Website (screenshots) Louisiana Provider Directory (electronic file; PDF) Louisiana Behavioral Health Provider Directory (electronic file; PDF)	Full	This requirement is met through the documents: Provider Directories (P/P), pages 4-5 Provider Directories: Louisiana Provider Directory (hard copy, full version) Louisiana Behavioral Health Provider Directory (hard copy, full version) Unable to locate the other documents listed	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Louisiana Provider Directory (hard copy, abbreviated version) Louisiana Behavioral Health Provider Directory (hard copy, abbreviated version)			
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Provider Directories (P/P)	Full	This requirement is met through the documents: Provider Directories (P/P), page 5	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	Provider Directories (P/P) Provider Directories: Louisiana Provider Directory (hard copy, full version) Louisiana Behavioral Health Provider Directory (hard copy, full version) Louisiana Provider Directory (electronic file; PDF) Louisiana Behavioral Health Provider Directory (electronic file; PDF)	Full	This requirement is met through the documents: Provider Directories (P/P), page 5 Louisiana Behavioral Health Provider Directory (electronic file; PDF), page 10.	
12.17.15	**Members' Rights and Responsibilities**				
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	Provider Handbook Member Handbook: Integrated Health Services Member Rights and Responsibilities-LA New Provider Orientation	Full	This requirement is met through the documents: Provider Handbook, pages 46-48 Member Handbook: Integrated Health Services, pages 62-66 Member Rights and Responsibilities-LA, pages 1-6 New Provider Orientation, slide 23-24	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Provider Handbook Member Handbook: Integrated Health Services Member Rights and	Full	This requirement is met through the documents: Provider Handbook, pages 46-48	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Responsibilities-LA New Provider Orientation		Member Handbook: Integrated Health Services, pages 62-66 Member Rights and Responsibilities-LA, pages 2-6 New Provider Orientation, slide 23-24	
12.17.16	**Member Responsibilities**				
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	Provider Handbook Member Handbook: Integrated Health Services Member Rights and Responsibilities-LA	Full	This requirement is met through the documents: Member Rights and Responsibilities-LA, page 4-5 Provider Handbook, page 47 Member Handbook: Integrated Health Services, pages 65-66	
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: Informing the MCO of the loss or theft of their ID card; Presenting their MCO ID card when using health care services; Being familiar with the MCO procedures to the best of the member's abilities; Calling or contacting the MCO to obtain information and have questions answered; Providing participating network providers with accurate and complete medical information; Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; Living healthy lifestyles and avoiding behaviors know to be detrimental to their	Member Handbook: Integrated Health Services Member Rights and Responsibilities-LA	Full	This requirement is met through the documents: Member Handbook: Integrated Health Services, page 65 Member Rights and Responsibilities-LA, pages 4-5	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	health; Following the grievance process established by the MCO if they have a disagreement with a provider; and Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.				
12.18	**Notice to Members of Provider Termination**				
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	Timely Notification of Participating Provider Agreement (P/P) Sample Member Letter – Provider Termination	Full	This requirement is met through the documents: Timely Notification of Participating Provider Agreement (P/P), pages 5-6 Sample Member Letter – Provider Termination, page 1	
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	Timely Notification of Participating Provider Agreement (P/P) Sample Member Letter – Provider Termination	Full	This requirement is met through the documents: Timely Notification of Participating Provider Agreement (P/P), page 6 Sample Member Letter – Provider Termination, page 1	
12.19	**Oral and Written Interpretation Services**				
12.19.1	In accordance with 42 CFR §438.10(b)(1) DHH shall provide on its website the prevalent non-English language spoken by enrollees in the state.				
12.19.2	The MCO must make real-time oral	Oral Translation Services	Full	This requirement is met through the	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	Member Handbook: Integrated Health Services		documents: Oral Translation Services, pages 1-3 Member Handbook: Integrated Health Services, page 5	
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	Requests for Translations and Alternate Formats of Member Communications Member Handbook: Integrated Health Services Member Written Materials Guidelines – LA Desktop Process	Full	This requirement is met through the documents: Requests for Translations and Alternate Formats of Member Communications, page 1 Member Handbook: Integrated Health Services, page 5 Member Written Materials Guidelines – LA Desktop Process, page 2	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**				
13.2	**General Grievance System Requirements**				
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 2 and Member Complaints and Grievances-LA, page 1.	
13.2.2	**Filing Requirements**				
13.2.2.1	**Authority to File**				
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 10 and Member Complaints and Grievances-LA, page 5.	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 10 and Member Complaints and Grievances-LA, page 5.	
13.2.3	**Time Limits for Filing** The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 11, Member Complaints and Grievances-LA, page 5 and Member Handbook, page 56.	
13.2.4 13.2.4.1	**Procedures for Filing** The member or provider may file an appeal either orally or in writing.	Member Appeals – Core Process – LA	Full	This requirement is addressed in Policy Member Appeals-Core Process-LA and the Member Handbook, Provider Manual and denial letters. Substantial In denial letter. Provider letter.	
13.2.4.2	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall	Member Appeals – Core Process – LA Member Complaints and	Substantial	This requirement is addressed in Member Appeals-Core Process-LA, page 11, Member Complaints and Grievances-LA, page 5 and Member	Job Request e-mail for posting grievance form on member website Grievance Form

Member Grievances and Appeals					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	Grievances - LA		Handbook, pages 56-59. Per Member Complaints and Grievances-LA, page 5, forms for filing grievances, appeals, concerns or recommendations will be made available on the member website. The MCO member website was reviewed and includes forms for requesting fair hearing, appeal and continuation of benefits. These forms are available in English and Spanish. The website does not include a form for filing a grievance. Under the section "Newsletters and more" on the website, members are provided a link to submit comments to AMG. Grievances are not addressed. The plan provided an appeal form for review, but grievance forms were not available for review. **Recommendation for Amerigroup Louisiana, Inc.** The plan should make forms for filing grievances available to members as per requirement. In its response to the draft report, Amerigroup Louisiana, Inc. is making provisions to update its website. Review determination is unchanged.	A job request to have the member grievance form uploaded to both the public and secure member website. An expedited request was submitted t – completion date by April 2017 as a change needed be made to the document.
13.3	**Grievance/Appeal Records and Report**				
13.3.1	The MCO must maintain records of all grievances and appeals. A copy of grievances	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 10, Member	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	Member Complaints and Grievances – LA Record Retention Schedule		Complaints and Grievances-LA, page 5 and Record Retention Schedule.	
13.3.2	The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	Member Appeals – Core Process – LA Member Complaints and Grievances – LA 113 Appeals Report Cover Letter Template 113 Appeals & State Fair Hearing May 2016	Full	This requirement is addressed for grievances in Member Complaints and Grievances-LA, page 5. The sample Grievance Report provided includes monthly summary data. The plan provided evidence onsite of member level grievance reports, which includes required information in a database. Member Appeals-Core Process-LA, page 10, discusses internal tracking, analysis and reporting of appeals. The Appeals Report cover letter template and Appeals and State Fair Hearing report for May 2016 are compliant. The Regulatory Reports spreadsheet includes monthly reporting of grievances and appeals.	
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	Member Complaints and Grievances - LA	Substantial	Member Complaints and Grievances-LA, page 6 addresses "DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal", but does not address "The MCO will be	Member Complaints and Grievances – LA; Procedure, Page 6 – added text to reflect MCO's responsibility to promptly forward any adverse decisions to LDH

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member." As per onsite staff, a DHH request would come through the regulatory email inbox and would be responded to immediately. **Recommendation for Amerigroup Louisiana, Inc.** The MCO should include prompt submission of adverse decisions to LDH for review on request by LDH or MCO member in policy. In its response to the draft report, Amerigroup Louisiana, Inc. added text to reflect its responsibility to forward adverse decisions to LDH. Since the revision was made after the review period, the review determination is unchanged.	
13.4	**Handling of Grievances and Appeals**				
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:				
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	Member Appeals – Core Process – LA Member Complaints and Grievances – LA LA-MEM-0119-13 Appeal Acknowledgment Verbal Letter LA-MEM-0113-13-T Appeal Acknowledgment Written	Full	Addressed in Member Appeals-Core Process-LA, page 4, Member Complaints and Grievances-LA, page 7, LA-MEM-0119-13 Appeal Acknowledgment Verbal Letter and LA-MEM-0113-13-T Appeal Acknowledgment Written Letter. File review 11/11 applicable grievances (i.e. not resolved on same day) and 10/10 appeals were acknowledged	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Letter		in writing within five days.	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 18 and Member Complaints and Grievances-LA, page 5.	
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Substantial	Addressed in Member Complaints and Grievances-LA, page 6. Member Appeals-Core Process-LA, page 18 partially addresses this requirement. Under Handling of Appeals, 1, e, ii. The policy states “who, if deciding any of the following…” “Any of the following” is not defined, e.g., an appeal of a denial that is based on lack of medical necessity, an appeal that involves clinical issues. File review 10/10 appeals and 3/3 applicable grievances were reviewed by appropriate clinical staff. It was not clear in one grievance file whether a clinical issue was involved, and the case did not appear to be referred for clinical review. Onsite staff demonstrated an updated tracking database that has been developed for grievances in which it is clear which are referred to other departments for review and resolution of the additional review. **Recommendation for Amerigroup Louisiana, Inc.** The plan should update the	Member Appeals Core Process – LA; # e(ii), Page 17 of 25 – the policy was revised to reflect the requirement language.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Member Appeals-Core Process policy to include the required language and continue to maintain the updated tracking process for grievances. In its response to the draft report, Amerigroup Louisiana, Inc. revised its policy to reflect the required language. Since the revision was made after the review period, the review determination is unchanged.	
13.4.2	**Special Requirements for Appeals** The process for appeals must:				
***13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services LA-MEM-0119-13 Appeal Ack Verbal	Full	Addressed in Member Appeals-Core Process-LA, page 3, Member Handbook, pages 55-56 and LA-MEM-0119-13 Appeal Ack Verbal.	
***13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal	Minimal	The Member Appeals-Core Process-LA, page 18, does not address opportunity to present in person, only in writing. Page 20 addresses opportunity to present evidence in writing as well as in person for expedited appeals. The Member Handbook addresses this requirement on page 56. Page 56 informs the member of the opportunity to appeal and submit a written request including information such as the care you are looking for, people involved, and having their doctor submit medical information about this	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes Member Handbook, Expedited Appeals; printed pages 57-58 The statement "If you are requesting an expedited resolution, please be advised of the limited time available to present evidence in person and in writing" was added to the appeal acknowledgment letters and the member handbook.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				service. Onsite staff provided an updated Member Handbook with an insert dated May 2016 that addresses the requirement to provide the member reasonable opportunity to present evidence, and allegations of fact or law, in person. Neither the submitted denial notice template nor acknowledgment letter templates address this requirement. However, updated letter templates dated 9/12/16 were provided onsite for review and are compliant, though outside the review period. The Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal states that upon receipt of an appeal, the plan attempts to phone the member to obtain information verbally if no information is submitted with the appeal. If the member has information to submit, the member is advised to submit the information in writing (fax number provided) or member can bring information in person to the plan. During the call, the member is informed of the limited time available for expedited appeals. If the member cannot be reached by phone, the plan processes the appeal using the original information provided. The denial	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				notice template, acknowledgment letter templates and Member Handbook do not inform the member that they will be contacted by phone. File review 10/10 appeals files did not include information relevant to presenting evidence in person. These cases predate the updated letter templates. **Recommendation for Amerigroup Louisiana, Inc.** The plan should implement updated denial and appeal letter templates that include required language. The plan should include the limited time available for presenting evidence for expedited appeals in denial letters and the Member Handbook. In its response to the draft report, Amerigroup Louisiana, Inc. revised the Member Handbook and Appeal letters. Since the revision was made after the review period, the review determination is unchanged.	
***13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services Desktop Process: Member Process to Present Evidence for Appeals & Member Process to Examine Case File	Minimal	Member Appeals-Core Process-LA, page 18, addresses this requirement. Neither the submitted denial notice template nor acknowledgment letter templates address this requirement. The appeal resolution notice (upheld) informs the member that the	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes The statement “member and his or her representative have the opportunity, before and during the

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		& Documents for Appeal		standards used to decide the appeal and the documents and data collected in reviewing the appeal are available to the member. This is not sufficient since the appeal is already completed at this point. The Member Handbook update provided onsite addresses this requirement on page 3. The Member Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal states that upon receipt of an appeal, the plan attempts to phone the member. During the phone call, the member is advised of this opportunity. **Recommendation for Amerigroup Louisiana, Inc.** The denial notice and acknowledgment letters should advise the member of their opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. In its response to the draft report, Amerigroup Louisiana, Inc. revised the acknowledgement letters. Since the revision was made after the review period, the review determination is unchanged.	appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process" was added to the acknowledgement letters.
***13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or	Member Appeals – Core Process – LA	Full	Member Appeals-Core Process-LA, page 18 addresses this	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the legal representative of a deceased member's estate.	Member Handbook: Integrated Health Services		requirement. File Review 10/10 reviewed appeals met this requirement.	
***13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	Training Log NCC G&A Training Syllabus	Full	Addressed in the Training Log and the NCC G&A Training Syllabus.	
****13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Appropriate Personnel for Decision Making	Full	Addressed in the position descriptions provided for: BH Care Management Director, Medical Director, Pharmacist Clinical Senior, Pharmacist Lead, Physician Reviewer, Senior Clinical Director, Staff VP Medical Director and Psychologist Reviewer.	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in §13.6 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 12.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	Member Appeals – Core Process – LA LA-MEM-0378-16 Member Uphold Notice	Full	Addressed in Member Appeals-Core Process-LA, page 23 and LA-MEM-0378-16 Member Uphold Notice.	
13.5	**Notice of Action**				
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and Section 12 of this RFP to ensure ease of understanding.	Denial Notice Template Wells Template	Full	Addressed in the Denial Notice Template. File Review 10/10 denials met this requirement.	
13.5.2	**Content of Notice of Action**				

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	The Notice of Action must explain the following:				
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 20 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement.	
13.5.2.2	The reasons for the action;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 20 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement	
13.5.2.3	The member's right to file an appeal with the MCO;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 21 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 22 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement.	
13.5.2.5	The procedures for exercising the rights specified in this section;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 21 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.5.2.6	The circumstances under which expedited resolution is available and how to request it;	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 21 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement.	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 22 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement	
13.5.2.8	Oral interpretation is available for all languages and how to access it.	Denial Notice Template Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 6 and the Denial Notice Template. File review 10/10 reviewed denials met this requirement	
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:				
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except:	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 20.	
13.5.3.1.1	The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following: • In the death of a recipient; • A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 20.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• The recipient's admission to an institution where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or • As otherwise permitted under 42 CFR §431.213.				
13.5.3.2	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	Claims Payment Appeal Management - LA	Full	Addressed in Claims Payment Appeal Management-LA, page 1.	
13.5.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 7. File review 10/10 reviewed denials files met this requirement.	
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the	Health Care Management Denial - Core Policy - LA	Full	Addressed in Member Appeals-Core Process-LA, page 12. File review All applicable files met this requirement.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	date the extension expires.				
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.5.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 7.	
13.5.3.6	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 2. File review All applicable reviewed denials met this requirement.	
13.5.3.7	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Health Care Management Denial - Core Policy - LA	Full	Addressed in Health Care Management Denial - Core Policy – LA, page 3. File review There were no applicable files reviewed.	
13.5.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.				
13.6	**Resolution and Notification**				
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	Member Appeals – Core Process – LA Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 21 and Member Complaints and Grievances-LA, page 6.	
13.6.1	**Specific Timeframes**				
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	Member Complaints and Grievances - LA	Full	Addressed in Member Complaints and Grievances-LA, page 6. File review 15/15 reviewed grievances met this requirement	
13.6.1.2	**Standard Resolution of Appeals**	Member Appeals – Core	Full	Addressed in Member Appeals-	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	Process – LA		Core Process-LA, page 21. File review 10/10 reviewed appeals met this requirement.	
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 21. File review All applicable files reviewed met the requirement.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	Member Appeals – Core Process – LA Member 14 day Extension notice Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 3, Member Complaints and Grievances-LA, page 6 and Member 14 day Extension notice. File review There were no applicable files reviewed.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	Member Appeals – Core Process – LA Member 14 day Extension notice Member Complaints and Grievances - LA	Full	Addressed in Member Appeals-Core Process-LA, page 3, Member Complaints and Grievances-LA, page 7 and Member 14 day Extension notice.	
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	Member Appeals – Core Process – LA Member Appeal Upheld Letter Member Appeal Overturned Letter Member Complaints and	Substantial	For grievances, partially addressed in Member Complaints and Grievances-LA, page 6 and Member 14-day Extension notice, page 4 and page 6. This policy does not specifically state that the notice is provided in writing. Grievance Resolution Letter template addresses this requirement. For appeals, the requirement is addressed in Member Appeals-	Member Complaints and Grievances – LA; Policy Page 1; Timeliness for Filing, Page 7 - Added "written resolution" as well as text reflecting resolution letter All Grievances are tracked and trended and reported monthly. An internal trending of complaints is analyzed quarterly to identify reoccurring or high trending issues as

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Grievances - LA Grievance Resolution Letter		Core Process-LA, pages 20-21, Member Appeal Upheld Letter and Member Appeal Overturned Letter. File review 11 of 15 reviewed grievance files included written notices of disposition. Three of the remaining files originated at LDH, and the plan indicated that they do not sent written notices for grievances that originate at LDH. The other remaining file did not include a resolution notice. 10/10 reviewed appeals files met this requirement. **Recommendation for Amerigroup Louisiana, Inc.** The plan should consider initiating a process to ensure that the plan is aware that grievances referred from LDH are resolved and members notified of resolution. Internally received complaints should all receive written notices of resolution, and this requirement for written notice should be included in policy. For two of the grievances, the issue involved assignment of a PCP who was not accepting patients. The plan should ensure that trends that are identified are investigated as to systematic issues that may be generating complaints. In its response to the draft report, Amerigroup Louisiana, Inc.	well as providers

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				indicated that is currently tracks and trends grievances monthly and updated its policy to reflect required language. It is recommended that the plan closely monitor grievances that are reported and implement a process to ensure that when members request a new provider that they are accepting new patients. Perhaps member services staff should be trained/retrained on identifying providers with open panels before a new PCP is assigned. Since the revision to policy was made after the review period and one of the 15 case files reviewed did not include a resolution letter, the review determination is unchanged.	
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.	Member Appeals – Core Process – LA Member Appeal Upheld Letter Member State Fair Hearing and COB Request Form COB Member Appeal Overturned Letter	Full	Addressed in Member Appeals-Core Process-LA, page 21, Member Appeal Upheld Letter and Member State Fair Hearing and COB Request Form. File review 10/10 reviewed appeals files met the requirement.	
13.6.5	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.				
13.6.5.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 23 and	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.			Member Appeal Upheld Letter. File review 10/10 reviewed appeals files included the required information	
13.6.5.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 23. File review All reviewed appeals met this requirement	
13.7	**Expedited Resolution of Appeals**				
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 20.	
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	Member Appeals – Core Process – LA Provider Handbook	Full	Addressed in Member Appeals-Core Process-LA, page 3 and the Provider Handbook, pages 50-51.	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request	Member Appeals – Core Process – LA Denial notice	Full	Addressed in Member Appeals-Core Process-LA, pages 20-21 and the Denial Notice Template. File review Applicable appeal files met this requirement Recommendation The plan should consider including the reason for converting an	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.			appeal filed as expedited to a standard appeal in the written notice.	
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 12.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 20.	
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Desktop Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal	Minimal	This information is provided verbally to the member per the "Desktop Process to Present Evidence for Appeals & Member Process to Examine Case File & Documents for Appeal." If the member is not reached by phone, it is not clear how the member is informed of this requirement. Neither the Denial Notice nor Acknowledgement Letter templates address this requirement. **Recommendation for Amerigroup Louisiana, Inc.** The plan should include the limited time available for presenting	LA-MEM-0113-13-T Appeal Ack Written with tracked changes LA-MEM-0119-13_Appeal_Ack_Verbal_ENG_with tracked changes This was added to the acknowledgment letters.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				evidence for expedited appeals in denial letters. In its response to the draft report, Amerigroup Louisiana, Inc. revised the acknowledgement letter. Since the revision was made after the review period, the review determination is unchanged.	
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 20.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 20.	
13.8	**Continuation of Benefits**				
13.8.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.				
***13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: • The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and	Member Appeals – Core Process – LA State Fair Hearing and COB Enclosure Member Handbook: Integrated Health Services	Full	Addressed in Member Appeals-Core Process-LA, page 19, State Fair Hearing and COB Enclosure, page 2, and Member Handbook, pages 58-59.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• The member requests extension of benefits.				
***13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	Member Appeals – Core Process – LA Member Handbook: Integrated Health Services	Full	Addressed in Member Appeals-Core Process-LA, page 19 and Member Handbook, pages 58-59.	
***13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	Member Appeals – Core Process – LA State Fair Hearing and COB Enclosure Member Handbook: Integrated Health Services	Full	Addressed in Member Appeals-Core Process-LA, page 19, State Fair Hearing and COB Enclosure, page 2, and Member Handbook, pages 58-59.	
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g) (1) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Handbook	Full	Addressed in Provider Handbook, page 112.	
13.10	**Recordkeeping and Reporting Requirements**				
13.10.0	Reports of grievances and resolutions shall	Member Complaints and	Full	Addressed in Member Complaints	

Member Grievances and Appeals					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	Grievances - LA		and Grievances-LA, pages 4-5.	
13.11	**Effectuation of Reversed Appeal Resolutions**				
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, pages 19-20.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	Member Appeals – Core Process – LA	Full	Addressed in Member Appeals-Core Process-LA, page 20.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**				
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:				
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QM Program Description 2016	Full	The requirement is addressed in the 2016 Quality Management Program Description, which outlines goals and strategies for monitoring and evaluating improvement.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QM Program Description 2016	Full	The requirement is addressed in the 2016 Quality Management Program Description, which references the identified strategies, and is evidenced by the Amerigroup Louisiana 2016 QM Work Plan, submitted Performance Improvement Projects (PIPs), Measurement Year 2015 HEDIS measure and non-HEDIS measure reports, member and provider surveys and utilization reports.	
14.1.4	Detect and address underutilization and overutilization of services	QM Program Description 2016	Full	The 2015 QM Program Evaluation includes reporting and analysis of Emergency Department, Inpatient and Outpatient utilization with objectives for improvement in 2016. Monitoring for over and under-utilization is addressed in the 2016 UM Program Description page 15, 19 and 51-56, and addresses monitoring and intervention strategies for readmissions, pharmaceuticals, home health, DME, behavioral health and inpatient utilization. The requirement is also addressed in the 2016 Quality Management Program Description page 22 and the 2016 QM Work Plan page 4. The plan provided examples of intervention strategies, such as those demonstrated in the LALA 39-week Initiative Provider Update, which addresses overutilization of early elective delivery, and the Kickoff Medicaid Expansion-Cardiology presentation.	
14.1.5	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated	LALA 39 Week Provider Update	Full	This requirement is addressed in provider update for the LALA 39-week Initiative and presentations of the Kickoff Medicaid	The details surrounding this requirement will be reviewed and added to the

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	Kickoff Medicaid Expansion Cardiology Radiation Oncology Sleep LAPEC 102016 AIM Update Provider Notification AIM Notice DME Notice LAPEC 0940-16 DME Rental Cap Provider Update		Expansion-Cardiology, Sleep Disorders and Radiation Oncology, which are also addressed in the provider notification form LAPEC_102016 AIM Update Provider. Strategies for Durable Medical Equipment (DME) are addressed in the LAPEC-0940-16 DME Rental Cap Provider Update. These initiatives were approved by DHH prior to implementation. Recommendation Amerigroup should consider including these components of its quality improvement strategy in work plans and track and evaluate the initiatives.	work plans as applicable
14.1.6	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description page 22 for some services (e.g. LARC). The plan has implemented Performance Improvement Projects for perinatal care, including reduction of underutilization of 17 hydroxyprogesterone, HIV and Syphilis screening in pregnant women and use of LARC, as evidenced by the 2015 QM Program Evaluation, LA Preterm PIP Report and the QM Work Plan page 21. Behavioral therapy for ADHD and other disorders in young children is addressed by the 2016 ADHD PIP Provider ADHD Survey, which was very well done and included analysis. Sickle cell disease is an included condition in Complex and Chronic Care Disease Management and prevention of crises is addressed in the Sickle Cell Care Plan. Clinical practice guidelines include ADHD and Sickle Cell Disease as per the Clinical Practice Guidelines Matrix. The 2015 QM Program Evaluation pages 85-91 documents trending	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				and efforts to improve postpartum visits, adolescent well care visits, and Chlamydia screening. Onsite staff described Case Managers work with Emergency Medical Services to address primary care under-utilization.	
14.1.7	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	QM Program Description 2016	Full	The 2016 QM Program Description Attachment A states that one of the responsibilities of the Plan's Behavioral Health Advisory Workgroup is to develop a program to align assessment and treatment with best practice standards for ADHD in children, especially in those younger than age 6. Onsite staff indicated that prior authorization for ADHD medication for children younger than 6 years is in place. Amerigroup addresses overutilization of early induction prior to 39 weeks through its 39 week initiative described above in 14.1.5.	
14.1.8.	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 11, the 2016 QM Work Plan page 3, Policy Special Needs Population-LA and the 2015 QM Program Evaluation page 77-84. This requirement is also addressed in the Disease Management Report 072016-092016	
14.1.9	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 41. Promoting Electronic Health Records is an objective in the 2016 QM Program Description. Onsite staff indicated that promotion of this incentive was promoted by provider relations. Staff was not aware how many providers had enrolled in the program. Recommendation	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Amerigroup should consider tracking success of provider education and outreach in order to evaluate which strategies are most effective.	
14.1.10	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI Program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.	QM Program Description 2016	Full	The document 2016 QM Program Description generally addresses the requirement. However on page 16, this document references race, ethnicity and language but does not address disability and geography. The plan did report utilization of 17 hydroxyprogesterone by region in the 2015 QM Program Evaluation. Onsite staff provided evidence of demographically stratified performance measures (diabetes). The plan described targeted efforts to improve diabetes care and control by region with highest prevalence.	
14.1.11	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description page 13-15 and 17-18, and in Appendix A as a requirement of the Provider Advisory Committee. Prioritization of QAPI activities was discussed with onsite staff. Priorities are selected based on performance measure trends, stratified results and review and discussion by plan medical directors. The 2015 QM Program Evaluation identifies opportunities and objectives for 2016.	
14.1.12	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description pages 13-19.	
14.1.14	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description page 10 and Appendix A page 36, which states the Health Plan Board of Directors, has delegated oversight of the QAPI Program to the Medicaid Quality Improvement Committee (QIC).	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Committee minutes were provided onsite and provide evidence of meeting this requirement.	
14.1.15	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	QM Program Description 2016 2016 AGPLA QM Work Plan	Full	The requirement is addressed in the 2016 QM Program Description page 6 and the 2016 QM Work Plan pages 1-2. Committee minutes were provided for the Medical Advisory Committee that demonstrate participation of multiple provider representatives	
14.1.16	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.	QM Program Description 2016 Bayou Health Reporting_2016 AMG 2015	Full	The requirement is addressed in the document (email) Bayou Health Reporting_2016 AGM 2015.	
14.1.17	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence-based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	CPG_ADHD LAPEC-0948-16 ADHD Follow-Up Visits_FINAL	Full	The AAP ADHD clinical practice guideline submitted by the Plan addresses this requirement. The plan also submitted a Provider Update document that addresses ADHD medication follow-up visits. The plan has implemented a performance improvement project (PIP) that addresses first line ADHD care for young children among other ADHD care elements.	
14.1.18	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	Peer Review – LA Network Development and Management Plan final 14.1.18 Current	Full	The requirement is addressed in the Policy Peer Review-LA and the Network Development and Management Plan, as well as HEDIS Provider Scorecards and BH Inpatient and Outpatient Medical Record Review and Practitioner Clinical Medical Record Review. .	
14.1.19	The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.	MCO_IMT Meeting	Full	This requirement is met by submission of an email from Louise Bowie verifying participation of Dr. Poliquit in Medicaid Quality Committee meetings. There was also an email from David Peterson submitted (MCO-IMT) that indicates that MCO participation in IMT meetings has not been directed by DHH.	
14.1.20 14.1.20.1 14.1.20.2	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or	BH utilization reports P/P BHUM Outcome measures and evidence that was shared	BH Treatment Outcomes_Q1 2016	Document Document	Entire Document Entire Document

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	with DHH Outcome measures and results BH outcome measures and evidence shared with DHH	BH Treatment Outcomes_Q2 2016 BH Treatment Outcomes_Q3 2016 BH Outcomes Plan 2016	Document Document Overview	Entire Document Entire Document Page 1,2
	For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual base.	Report Submission Q3 Report Submission Q1 Q2 Q4 Mental Health Rehabilitation Services - L	Full	The Plan submitted copies of emails with evidence of submission of quarterly submission of Behavioral Treatment Outcomes Reports and the BH Outcomes Plan 2016.	
14.2	**QAPI Committee**				
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:				
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28.	
14.2.1.2	The MCO Behavioral Health Director;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28. Onsite staff provided a roster of members of the Health Education Advisory Committee, which includes member advocates and MCO members among the committee membership.	
14.2.1.5	The MCO shall include DHH	QM Program Description	Full	The requirement is addressed in the 2016	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	representative(s) on the QAPI Committee, as designated by DHH as non-voting member(s).	2016		QM Program Description Appendix A page 28.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description Appendix A page 28. Onsite staff provided meeting minutes for six LA Quality Management Committee meetings held during the review period.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28. LA Quality Management Committee meeting minutes demonstrate evidence of direction and review of QI activities.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix A page 28. LA Quality Management Committee minutes address this requirement and provide evidence of membership in the committee from a broad range of MCO departments.	
14.2.2.3	Review and suggest new and or improved QI activities;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 28 and in Appendix A description of QMC. LA Quality Management Committee minutes demonstrate evidence of review and development/modification of QI activities.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 19. Medical Advisory Committee minutes reveal activities of this committee relevant to improving Culturally and Linguistically Appropriate Services and addressing quality of care concerns.	
14.2.2.5	Designate evaluation and study design procedures;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Evaluation page 19.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 18.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				This requirement is evidenced by the Provider Scorecard and the Fidelity Monitoring Plan and the Provider Gap in Care Report	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 19 and LA Quality Management Committee minutes.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 22 and the 2015 QM Program Evaluation. UM presentations are also evident in LA Quality Management Committee minutes.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description pages 11 and 29. The plan provided minutes for the LA Quality Management Committee, Medical Advisory Committee and Health Education Advisory Committee.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management services;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 23, the 2015 QM Program Evaluation, and an email documenting submission of the QAPI Program Evaluation 2015-Bayou Health Reporting_216 AMG 2015.	
14.2.2.11	Ensure that the QAPI committee chair attends DHH quality meetings; and	QAPI Chair Attendance LDH	Full	The requirement is addressed in the QAPI Chair Attendance LDH email from the State.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QM Program Description 2016	Full	This requirement is addressed in the 2016 QM Program Description page 15 with regard to updating clinical practice guidelines every 2 years and Appendix A page 30. As per the 2016 QM Work Plan, clinical guidelines are reviewed quarterly by the Medical Advisory Committee and reported to the QMC, and overall are reviewed annually and distributed to providers. .	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days after the effective date of	Bayou Health Reporting_121 AMG 2015 2016 AGPLA QM Work Plan	Full	The requirement is addressed in the Bayou Health Reporting_121 AMG 2015 submission and the 2016 AGPLA QM Work Plan. The LA Quality Management Committee minutes from February 12, 2016 include review and approval of the 2016 QM Work	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:			Plan.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 8 and its Appendix A page 28. The 2016 AGPLA QM Work Plan includes interventions and goals, and provides for quarterly updates and assessment	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description pages 8 and 13 and is evidenced by the 2015 QM Program Evaluation and HEDIS and CAHPS Reports.	
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description Appendix B, and responsible parties for QAPI activities are identified in the 2016 QM Work Plan.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 29, Provider communication, monitoring and participation are included in the 2016 QM Work Plan, which addresses the plan Medical Advisory Committee. Medical Advisory Committee minutes demonstrate robust provider participation.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QM Program Description 2016	Full	The requirement is addressed by the 2016 AGPLA QM Work Plan, which is Louisiana Medicaid-specific.	
14.2.3.6	Describe the methods for ensuring data collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description pages 12-13 and in the 2016 AGPLA QM Work Plan, which refers to audited HEDIS data and effort to ensure data integrity for pharmacy and network. The plan provided examples of treatment record reviews and reports of results to audited providers.	
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of	Fidelity Monitoring Plan_14.2.3.7	Full	All elements of this requirement are addressed in the Fidelity Monitoring Plan. Fidelity monitoring reports are addressed in the 2016 Work Plan.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	review, and validation methods.				
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Results of the evaluation of the impact and effectiveness of the QAPI program.	AGPLA QM Program Eval for CY 2015 QM Program Description 2016	Full	These requirements are addressed in the 2016 QM Program Description page 7, the 2015 QM Program Evaluation.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.	QM Program Description 2016	Full	These requirements are addressed in the 2016 QM Program Description Appendix A page 42 and emails documenting submitted monthly reports- Report Submissions March 2016_14.8 through Aug2016_14.8, which include Chisolm ASD, Aging Out, BH Out of State Placement and BH Adverse Incident report. Report Submission Q3 is evidence of submission of the BH Treatment Outcome Report to DHH.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the *MCO Quality Companion Guide and the Behavioral Health Companion Guide.*	HEDIS Results ARTS Non-HEDIS Results_Measures	Full	These requirements are addressed in the documents HEDIS Results ARTS, Non-HEDIS Results_Measures, State HEDIS 2016 Submission (email with attachments), 2016 CAHPS Adult, 2016 CAHPS Child-CCC, and 2016 BH CAHPS, and the IDSS Amerigroup ARTs HEDIS 2016.	
14.2.5.2	The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.	HEDIS Results ARTS Non-HEDIS Results_Measures	Full	These requirements are addressed in documents HEDIS Results ARTS, Non-HEDIS Results and Measures, State HEDIS 2016. Provided onsite was the submission email (with attachments) for the 2016 CAHPS Adult, 2016 CAHPS Child-CCC, and 2016 BH CAHPS, and the IDSS Amerigroup ARTs HEDIS 2016.	
14.2.5.3	The MCO shall have processes in place to	Audit Report Attest	Full	The requirement is addressed in the 2016	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	monitor and self-report all performance measures.			QM Work Plan, HEDIS Audit Report Attest, HEDIS Results ARTS, Non-HEDIS Results_Measures, State Measures and State Targets-HEDIS2017_Admin_LA_May 2016,	
14.2.5.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	Amerigroup Non-HEDIS IPRO Submission	Full	The requirement is addressed in the Amerigroup Non-HEDIS IPRO Submission and State HEDIS 2016 Submission.	
14.2.5.5	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	State HEDIS 2016 Submission	Full	The requirement is addressed in the Amerigroup Non-HEDIS IPRO Submission and State HEDIS 2016 Submission.	
14.2.5.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Provider Score Card	Full	The requirement is addressed in the 2015 QM Program Evaluation, the 2016 QM Work Plan and HEDIS Results ARTs. Results are trended and improvement was noted in several performance measures, with strategies for improvement identified. This requirement is also addressed in the Behavioral Health Treatment Outcomes reports.	
14.2.5.7	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 13, and evidenced in State Measures and State Targets_HEDIS2017_Admin_LA_May2016, Gap in Care Reports, and Provider Score Card.	
14.2.5.8	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	QM Program Description 2016	Full	The requirement is addressed in the 2016 QM Program Description page 13.	
14.2.5.9 14.2.5.9.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$".	State Measures and State Targets_HEDIS 2017_Admin_LA_May 2016 LA Performance Measure Submission Guide 2016	Full	The requirement is addressed in the State Targets_HEDIS2017_Admin_LA_May2016 and the LA Performance Measure Submission Guide 2016.	
14.2.5.9.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.				
14.2.5.10	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based	Updated Performance Measure Submission Guide	Full	The requirement is addressed in the LA Performance Measure Submission Guide 2016.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.				
14.2.5.11 14.2.5.11.1	**Performance Measures Reporting** All measures contained in Appendix J MCO Performance Measures and the Behavioral Health Companion Guide are reporting measures.				
	14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH. 14.2.5.11.5 The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re- submissions. 14.2.5.11.6 The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.	IDSS Amerigroup ARTs HEDIS 2016 Final Audit Report Amerigroup-IAR Attest	Full	This requirement is addressed in HEDIS Results ARTs, Non-HEDIS Results_Measures, IDSS Amerigroup ARTs HEDIS 2016, and Final Audit Report Amerigroup –IAR Attest. BH Treatment Outcomes Reports address specialized behavioral health report submissions.	
14.2.5.12	**Performance Measure Goals** 14.2.5.12.1 The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the Bayou Health population.	HEDIS Based Provider Profile Administration Process	Full	This requirement is addressed in the LA Performance Measure Submission Guide 2016 and reflected in the document State Targets_HEDIS2017_Admin_LA_May2016.	
14.2.5.12.3	DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee. Final determination of goals is at the sole discretion and approval of DHH	HEDIS Based Provider Profile Administration Process	Full	This requirement is addressed in the LA Performance Measure Submission Guide 2016 and reflected in the document State Targets_HEDIS2017_Admin_LA_May2016. <u>Recommendation</u> The plan should consider referencing State performance goals in its QM Program	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Description/Program Evaluation/Work Plan.	
14.2.5.13	**Performance Measure Reporting** 14.2.5.13.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring. 14.2.5.13.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH. **Reporting Measures.** 14.2.5.13.4 The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting.	HEDIS Medical Record Review Policy – Quality Assurance HEDIS Based Provider Profile Administration Process Practitioner Clinical MRR BH OP MRR BH IP MRR Gap In Care Report	Full	The requirement is addressed in the 2016 QM Program Description pages 12-13, the document State Measures and State Targets_HEDIS2017_Admin_LA_May2016, BH Treatment Outcome reports, the HEDIS Medical Record Review Policy-Quality Assurance. Individual PCP profiles are addressed in the HEDIS Based Provider Profile Administration Process, Provider Score Card, Practitioner Clinical MRR, BH OP MRR, BH IP MRR and Gap in Care Reports.	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.240.	LA Prematurity PIP Report LA Prematurity PIP Meeting Minutes Nov 19 15	Full	This requirement is addressed in the 2016 AGPLA QM Work Plan page 21 (PIP Dashboard), the 2015 QM Program Evaluation pages 91-100, the LA Prematurity PIP Report, LA ADHD_Prematurity PIP Meeting Minutes and ADHD Provider Survey.	
14.2.8.2	The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. DHH may require up to two (2) additional projects for a maximum of four (4) projects.	ADHD PIP Project Provider ADHD Survey 2016	Full	This requirement is addressed in the LA Prematurity PIP Report, LA ADHD_Prematurity PIP Meeting Minutes and ADHD Provider Survey.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.	ADHD PIP Project Provider ADHD Survey 2016 ADHD Prematurity PIP LA_ Meeting Minutes 2 18 16	Full	This requirement is addressed in LA Prematurity PIP Report, LA ADHD_Prematurity PIP Meeting Minutes and ADHD Provider Survey.	
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: Measurement of performance using	Plan Project Prematurity PIP Interventions 10 6 15 PIP Premature Births Baseline 7 1 16	Full	This requirement is addressed 2016 AGPLA QM Work Plan page 21 (PIP Dashboard), the 2015 QM Program Evaluation pages 91-100, the LA Prematurity PIP Report, Plan Project Prematurity PIP Interventions 10 6 15, PIP Premature Births Baseline 7 1 16, LA ADHD_Prematurity PIP Meeting Minutes and ADHD Provider Survey.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	objective quality indicators; Implementation of system interventions to achieve improvement in quality; Evaluation of the effectiveness of the interventions; and Planning and initiation of activities for increasing or sustaining improvement.				
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include: An overview explaining how and why the project was selected, as well as its relevance to the MCO members and providers; The study question; The study population; The quantifiable measures to be used, including the baseline and goal for improvement; Baseline methodology; Data sources; Data collection methodology and plan; Data collection plan and cycle, which must be at least monthly; Results with quantifiable measures; Analysis with time period and the measures covered; Explanation of the methods to identify opportunities for improvement; and An explanation of the initial interventions to be taken.	PIP Premature Births Baseline 7 1 16	Full	This requirement is addressed in the report PIP Premature Births Baseline 7 1 16. The plan provided feedback on performance measures, data abstraction tools, and population and sampling for the ADHD PIP, and this is addressed in LA ADHD_Prematurity PIP Meeting Minutes and ADHD Provider Survey.	
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; Use clinical care standards and/or practice guidelines to objectively evaluate the care	PIP Premature Births Baseline 7 1 16	Full	The plan is participating in two collaborative PIPs, and this requirement is addressed in the report PIP Premature Births Baseline 7 1 16, the 2015 QM Program Evaluation and 2016 QM Work Plan.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the MCO delivers or fails to deliver for the targeted clinical conditions; Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; Evaluate the effectiveness of the interventions; Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; Reflect the population served in terms of age groups, disease categories, and special risk status, Ensure that multi-disciplinary teams will address system issues; Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and Maintain a system for tracking issues over time to ensure that actions for improvement are effective.				
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	2016 CAHPS Adult 2016 CAHPS Child CCC	Full	This requirement is addressed in the 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports, and CAHPS surveys are addressed in the 2016 QM Work Plan.	
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult	AmerigroupLA 2016 SOW	Full	The requirement is addressed in the Amerigroup LA 2016 SOW document, as well as the 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.				
14.2.10.4	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	Submission of CAHPS 2016	Full	The requirement is addressed in the email Submission of CAHPS 2016.	
14.2.10.5	The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	Submission of CAHPS 2016	Full	The requirement is addressed in the email Submission of CAHPS 2016 and appended 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	2016 CAHPS Adult 2016 CAHPS Child CCC	Full	The requirement is addressed in the AmerigroupLA_2016 SOW and the 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	2016 CAHPS Adult 2016 CAHPS Child CCC	Full	The requirement is addressed in the AmerigroupLA_2016 SOW and the 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports. LA Quality Management Committee minutes include discussion of CAHPS results and action plans.	
14.2.10.8	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Global Ratings.	2016 CAHPS Adult 2016 CAHPS Child CCC	Full	This requirement is addressed in the 2016 CAHPS Adult and 2016 CAHPS Child_CCC reports.	
14.2.10.9	The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.	2016 CAHPS BH	Full	The requirement is addressed in the 2016 CAHPS BH Report.	
14.4	**Health Plan Accreditation**				
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting	LA01801 Certificate_2015 LA01802 Final	Full	The requirement is addressed in the LA01801 Certificate_2015 and LA01801 Final Certificate_2016.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	NCQA accreditation standards.	Certificate_2016			
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	LA01801 Certificate_2015 LA01802 Final Certificate_2016	Full	The requirement is addressed in the LA01801 Certificate_2015 and LA01801 Final Certificate_2016.	
14.4.3	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	LA01801 Certificate_2015 LA01802 Final Certificate_2016	N/A	The requirement is addressed in the LA01801 Certificate_2015 and LA01801 Final Certificate_2016 documents. The plan achieved New Health Plan accreditation in 2015 and Commendable accreditation in 2016.	
14.5	**Member Advisory Council**				
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	PS141 Member Advisory Council 2016	Full	The requirement is addressed in report PS141 Member Advisory Council Plan 2016. The Member Advisory Council was renamed the Health Education Advisory Committee.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	PS141 Member Advisory Council 2016	Full	The requirement is addressed in document PS141 Member Advisory Council 2016. The Member Advisory Council was named the Health Education Advisory Committee during the review period, and committee minutes reveal quarterly meetings. Meeting membership includes the President of Amerigroup LA Medicaid Health Plan.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at	PS141 Member Advisory Council 2016	Full	This requirement is addressed in the 2016 QM Program Description Appendix A page 33. Onsite staff provided a roster of members that include member, advocate, and provider representation. Members and advocates make up more than 50% of membership.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	least fifty per cent (50%) of the membership.				
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	PS141 Member Advisory Council 2016	Full	This requirement is addressed in the 2016 QM Program Description Appendix A page 33. This requirement is addressed in the document PS141 Member Advisory Council 2016 Plan, which references initial and ongoing training for members. Health Education Advisory Committee meeting minutes include topic-specific presentation to membership. Evidence of orientation training was not provided. Onsite staff indicated that membership has been stable in the committee. Recommendation The plan should formalize orientation training for members to ensure understanding of membership responsibilities. In its response to the draft report, Amerigroup provided a PowerPoint educational presentation that it presents annually to its Member Advisory Committee. The review determination is changed to "fully Compliant"	Annually, Amerigroup Louisiana provides committee responsibility education in the form of a PowerPoint presentation at one of the quarterly meetings during the year. In addition, the education is provided to any new members. Health Education Advisory Committee Full Document
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter.	PS141 Member Advisory Council 2016 2016 Amerigroup PS141 Attestation	Full	The requirement is addressed in the 2016 QM Program Description page 33 and in PS141 Member Advisory Council 2016.	
14.5.6.	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally,	MAC Correspondence 2016 MAC Website Screenshot -	Full	These requirements are addressed in the 2016 QM Program Description Appendix A page 33, the MAC Correspondence 2016	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	Minutes		screenshot, and the MAC Website Screenshot-Minutes.	
14.6	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Family Functional Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards are met. A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by	Fidelity Monitoring Plan MOU_Amerigroup TKCL FFT Services MST_Amerigroup MOU signed Homebuilders_Amerigroup MOU Amerigroup_Homebuilders MOU	Full	These requirements are addressed in the Fidelity Monitoring Plan, MOUs for Amerigroup TKCL FFT, MST_Amerigroup, Amerigroup Homebuilders. Reporting is addressed in the 2016 QM Work Plan.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted to DHH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.				
14.8	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management. The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	BH Adverse Incidents Monitoring and Reporting - LA Adverse Incident Report Template Report Submission Aug2016_14.8 Report Submission July2016_14.8 Report Submission June2016_14.8 Report Submission May2016_14.8 Report Submission April2016_14.8 Report Submission March2016_14.8	Full	These requirements are addressed in the documents BH Adverse Incidents Monitoring and Reporting-LA, the Adverse Incident Report Template, and Report Submissions March 2016_14.8 through Aug2016_14.8 DHH. Onsite staff provided Bayou Health Incident Reports for review.	

Reporting					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
18.0	**Reporting**				
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	Process and Responsibilities for the Development, Review and Submission of Regulatory Reports (P&P) Screenshots of information systems Regulatory Reports The above referenced policy details the Plan's process to ensure consistency and accountability in the development and submission of all state required reports. Also included is a spreadsheet outlining all required reports including the business owner, frequency, deadline, etc.	Full	Addressed in Process and Responsibilities for the Development, Review and Submission of Regulatory Reports, screenshots of information systems and the Regulatory Reports spreadsheet.	

Fraud, Waste and Abuse					
Contract Reference	**Contract Requirement Language**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
15.1	**General Requirements**				
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235.				
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 PI / MFCU Meeting Invitation	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 121 Also through the PI/ MFCU Meeting Invitation	
15.1.3	The MCO shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 121	
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 121-122	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.				
15.1.5	MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 122	
15.1.6	The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page122	
15.1.7	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 122	
15.1.8	The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 122	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	program to their designated Program Integrity contact.				
15.1.9	The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 122	
15.1.10	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing and Re-credentialing for Licensed Independent Practitioners Disclosure Form - Provider Person ver121911	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 122 Credentialing and Recredentialing for Licensed Independent Practitioners, page 9 # 2 Disclosure Form-Provider Person Ver121911	
15.1.11	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Sample Hybrid Participating Provider Agreement Credentialing and Re-credentialing for Licensed Independent Practitioners	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 122-123 Sample hybrid Participating Provider Agreement: section 3.2, page 6 Credentialing and Re-credentialing for Licensed Independent Practitioners: Section I, page 25	
15.1.12	The MCO shall have adequate staffing and resources to investigate unusual incidents	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste,	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	LDH approval In-State Waiver Request - Fraud Investigator		and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123.	
15.1.13	The MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.13.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.13.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.13.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.14	This prohibition described above in Section 15.1.13 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.15	The MCO shall comply with all federal and state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Social Security Act.			Prevention, page 123	
15.1.16	**Reporting and Investigating Suspected Fraud and Abuse**				
15.1.16.1	The MCO shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.				
15.1.16.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 123	
15.1.16.3	The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when the concerns and/or allegations of any tips are authenticated.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Report 145 Q2 2016 AMG LA, Inc. - Quarterly Report Submission - Q2 2016 ENCRYPT	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 123-124 Also through Report 145 Q2 2016 and AMG LA, Inc. Quarterly Report Submission - Q2 2016 ENCRYPT	
15.1.16.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to DHH and the appropriate agency as follows:	2016 SIU Fraud, Waste, and Abuse Plan 20160322 145 Report Q2 2016 MCO Fraud Referral Template	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 Also through 145 Report Q2 2016 and MCO Fraud Referral Template	
15.1.16.4.1	All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to DHH and MFCU;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 MCO Fraud Referral Template 20160315 and 2016330_ AGP Tips Report	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 Also through MCO Fraud Referral Template and 20160315 and 2016330_ AGP Tips Report	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1.16.4.2	Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 MCO Fraud Referral Template 20160315 and 2016330_ AGP Tips Report	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 also through MCO Fraud Referral Template and 20160315 and 2016330_ AGP Tips Report	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	2016 SIU Fraud, Waste, and Abuse Plan 20160322 MCO Fraud Referral Template 20160315 and 2016330_ AGP Tips Report	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 Also through MCO Fraud Referral Template and 20160315 and 2016330_ AGP Tips Report	
15.1.16.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 MCO Fraud Referral Template 20160315 and 2016330_ AGP Tips Report	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 Also through MCO Fraud Referral Template and 20160315 and 2016330_ AGP Tips Report	
15.1.16.5	The MCO shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 MCO Fraud Referral Template	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124 Also through the MCO Fraud Referral Template	
15.1.16.6	The MCO shall be subject to a civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to DHH				

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	MFCU, as appropriate.				
15.1.16.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.7.1	Contact the subject of the investigation about any matters related to the investigation;	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.8	The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.9	The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.			Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 124	
15.1.16.10	The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 119	
15.1.17	The State shall not transfer its law enforcement functions to the MCO.				
15.1.18	The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125	
15.1.19	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Sample Hybrid Participating Provider Agreement	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125 and through Sample Hybrid	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Participating Provider Agreement page 10	
15.1.20	The MCO shall notify DHH when the MCO denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing and Re-credentialing for Licensed Independent Practitioners	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125 and through Credentialing and Re-credentialing for Licensed Independent Practitioners page 49	
15.1.21	Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.				
15.1.22	In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the MCO shall report overpayments made by DHH to the MCO as well as overpayments made by the MCO to a provider and/or subcontractor.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Report 145 Q2 2016	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125 Also through Report 145 Q2 2016	
15.1.23	The MCO shall have at least one (1) full-time investigator or full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 15.1.12 LDH approval In-State Waiver Request - Fraud Investigator	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page125	
15.2	**Fraud and Abuse Compliance Program**				
15.2.1	In accordance with 42 CFR §438.608(a), the MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125 Also through Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations	
15.2.2	In accordance with 42 CFR §438.608(b)(2), the	2016 SIU Fraud, Waste, and	Full	This requirement is met through the	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	MCO shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.	Abuse Plan 20160322 AGP Program Integrity Committee Structure		documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 125 Also through the AGP Program Integrity Committee Structure	
15.2.3	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Submission of FWA Plan to LDH	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126 Also through the Submission of FWA Plan to LDH	
15.2.3.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126	
15.2.3.2	Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126	
15.2.3.3	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126	
15.2.3.4	Provisions for the confidential reporting of plan violations, such as a hotline to report	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	violations and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;			2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126	
15.2.3.5	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126	
15.2.3.6	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations Non-Retaliation Policy 2016 July - Anthem Standards of Ethical Business Conduct	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126 Also through the Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations pages 5-6 Non-Retaliation Policy And the 2016 July - Anthem Standards of Ethical Business Conduct page 10	
15.2.3.7	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126 Also through Fraud, Waste, and Abuse Detection and Prevention in Health Plan page 4	
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 2016 July - Anthem Standards of Ethical Business Conduct)	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126 Also through the 2016 July - Anthem Standards of Ethical Business Conduct) on page 5 and 38	
15.2.3.9	Effective education for the Program Integrity Officer, program integrity investigators, managers, employees, providers and members to ensure that they know and understand the provisions of MCO's compliance plan;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 I Am Anthem 2016 (Annual training) New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page126 Also through the I Am Anthem 2016 (Annual training) and the New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL	
15.2.3.10	Fraud, Waste and Abuse Training shall include, but not be limited to: Annual training of all employees; New hire training within thirty (30) days of beginning date of employment.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 I Am Anthem 2016 (Annual training) New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 126 Also through the I Am Anthem 2016 (Annual training) and the New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL	
15.2.3.11	MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: MCO Code of Conduct Training	2016 SIU Fraud, Waste, and Abuse Plan 20160322 I Am Anthem 2016 (Annual training)	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322 , page 126-127 I Am Anthem 2016 (Annual training)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Privacy and Security – Health Insurance Portability and Accountability Act Fraud, waste, and abuse Procedures for timely consistent exchange of information and collaboration with DHH; Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.	New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL		and the New Hire Training Anthem - NAO-EPIC New Associate Training TOC_rev111814 Anthem - NAO EPIC New Associate Training_rev092016 Intro to HealthCare Fraud Scripts FINAL A reference to the Organizational chart and the collaboration with LDH is in the New Hire Training.	
15.3	**Prohibited Affiliations**				
15.3.1	In accordance with 42 CFR 438.610, the MCO is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.				
15.3.2	The MCO shall comply with all applicable provisions of 42 CFR 438.610 pertaining to debarment and/or suspension. The MCO shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 LDH Submission of Screening Reporting 148 AMG February 2016	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 127 Also through LDH Submission of Screening Reporting 148 AMG February 2016	
15.3.3	The MCO shall search the following websites: Office of Inspector General (OIG) List of	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Excluded Individuals/Entities (LEIE); Louisiana Adverse Actions List Search; The System of Award Management (SAM); and Other applicable sites as may be determined by DHH			2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 127	
15.3.4	The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2).	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse -Prevention, page 127-128	
15.3.4.1	An individual who is an affiliate of a person described above include: A director, officer, or partner of the MCO; A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing Program Integrity Sanction Review and Monitoring	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 128 Also through the Credentialing Program Integrity Sanction Review and Monitoring	
15.3.4.2	The MCO shall notify DHH within three (3) days of the time it receives notice that action	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.			2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 128	
15.4	**Payments to Excluded Providers**				
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services ; and	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page128	
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 128	
15.5	**Reporting**				
15.5.1	In accordance with 42 CFR 455.1(a)(1) and 455.17, the MCO shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 128	
15.5.2	Reporting shall include, but is not limited to,				

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	as set forth in 42 CFR 455.17:				
15.5.2.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (defined at 42 CFR 455.14);	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Report 145	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 128 Also through Report 145 Summary Tab, Fraud, Waste and Abuse	
15.5.2.2	Number of complaints reported to the Program Integrity Officer; and	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Report 145	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through Report 145 Tabs 1 and 3	
15.5.2.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide DHH, at a minimum, the following: Provider name and ID number; Source of complaint; Type of complaint; Nature of complaint; Approximate range of dollars involved if applicable; and Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Report 145	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page129 Also through Report 145 tabs 1 and 3. The Provider name is listed as "Entity Name'	
15.5.3	The MCO, through its compliance officer, shall attest to DHH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 LDH Submission of Screening Reporting 148 AMG February 2016	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the LDH Submission of Screening Reporting 148 AMG	

Fraud, Waste and Abuse					
Contract Reference	**Contract Requirement Language**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				February 2016	
15.6	**Medical Records**				
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA page 2, and pages 9-10.	
15.6.1.1	Accurate and legible;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page129 Also through the Medical and Treatment Record Review - LA page 2, and pages 9-10.	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA page 2	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page129 Also through the Medical and Treatment Record Review - LA page	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				2	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA page 2; and 9-10	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page129 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA pages 9-10	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 129 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.5	Referrals including follow-up and outcome of referrals;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.7	Signed and dated consent forms (as applicable);	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.8	Documentation of immunization status;	2016 SIU Fraud, Waste, and	Full	This requirement is met through the	Medical and Treatment Record

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Abuse Plan 20160322 Medical and Treatment Record Review - LA		documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9 Recommendation: The MCO should correct its P/P document so this requirement appears on its own line. In its response to the draft report, Amerigroup added text to appear on its own line.	Review – LA; #viii Page 9 - added text to its own line
15.6.2.9	Documentation of advance directives, as appropriate;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Medical and Treatment Record Review - LA	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the documents:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	Medical and Treatment Record Review - LA		2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Medical and Treatment Record Review - LA pages 9-10	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Member Handbook	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Member Handbook on page 63 of the document	
15.6.4	All documentation and/or records maintained by the MCO or any and all of its network providers shall be maintained for at least six (6) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Record Retention Schedule	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 130 Also through the Record Retention Schedule	
15.7	**Rights of Review and Recovery by MCO and DHH**				
15.7.1	Each MCO is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the MCO subcontracts to outside entities.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page130	
15.7.2	The MCO has the exclusive right of review and recovery for twelve 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud,	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	underpayment by delivering such notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.			Waste, and Abuse Prevention, pages 130-131	
15.7.3	All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the Department. This review period is inclusive of all provider notification, health plan document review, and including any provider appeal or rebuttal process. The MCO shall notify the Department, at least on a monthly basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 131	
15.7.4	The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 131	
15.7.5	If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim review recovery after 365 days from the date of notice to the Department of the collection status, unless in	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 131	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.				
15.7.6	The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of an improper payment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page131 Recommendation: It appears that the wording in the document should state "determine the existence of improper payments" instead of "mispayments" In its response to the draft report, Amerigroup corrected the language.	2017 SIU Fraud, Waste, and Abuse Plan was updated to reflect the recommended wording: **"determine the existence of improper payments"** **Section 15.7.6 Page 137**
15.7.7	DHH may recover from the provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page131	
15.7.8	DHH must notify the MCO of an identified improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payment(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 131-132	
15.7.9	The MCO shall not correct claims not initiate an audit on the claims upon notification by the Department or its agent unless directed to do so by the Department.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page132	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.7.10	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department of its agent will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund any amounts collected to the Department. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 132	
15.7.11	There will be no DHH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Bayou Health Contract period of for providers for which no MCO relationship existed.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 132	
	Additional PE-Related RFP Sections				
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Sample Hybrid Participating Provider Agreement Excluded Individuals and Entities – Prohibition on Hiring or Contracting	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 122, 123, 127-128 Also through the Sample Hybrid Participating Provider Agreement on page 6 and the Excluded Individuals and Entities – Prohibition on Hiring or Contracting	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
4.1.4	The MCO shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Criminal Background Checks HR	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 127-128 Also through the Criminal Background Checks HR	
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	AGP Key Staffing -016 AMG 2015	Full	This requirement is met through the document: AGP Key Staffing -016 AMG 2015	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Excluded Individuals and Entities - Prohibition on Hiring or Contracting	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 127 Also through the Excluded Individuals and Entities - Prohibition on Hiring or Contracting	
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Sample Hybrid Participating Provider Agreement	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 127 Also through the Sample Hybrid Participating Provider Agreement	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.			on page 19	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 127-128	
17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing Program Integrity Sanction Review and Monitoring	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 122, 127, 128 Also through the Credentialing Program Integrity Sanction Review and Monitoring	
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing and Recredentialing for Licensed Independent Practitioners Disclosure of Ownership Form 1.9.15 Credentialing Program Integrity Sanction Review and Monitoring	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page122 Also through the Credentialing and Recredentialing for Licensed Independent Practitioners page 9 Disclosure of Ownership Form 1.9.15 and the Credentialing Program Integrity Sanction Review and Monitoring pages 4,6, and 8	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Disclosure of Ownership Form 1.9.15	Substantial	This requirement is partially met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322, Section 15. Fraud, Waste, and Abuse Prevention, page 122. However, the MCO should add the language regarding ownership of subcontractors and business transactions to their documents. In its response to the draft report, Amerigroup Louisiana, Inc. created a new policy, dated 12/30/16 regarding disclosure of ownership. Review determination is unchanged since the policy ID is dated after the review period.	Medicaid Subcontractors Disclosure of Ownership; full document
18.3	**Report of Transactions with Parties in Interest –** 18.3.1 The MCO shall report to DHH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial	2016 SIU Fraud, Waste, and Abuse Plan 20160322 N/A The Plan states on the Readiness Review Submission Form – 15.0 Fraud, Abuse, and Waste Prevention, "As a wholly owned subsidiary of Anthem, Amerigroup Louisiana has no individual owners and therefore, there are no such transactions with	Full	Amerigroup does not have Individual Owners	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	statement for the MCO and the party in interest. 18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.	a "party in interest" to report.			
18.7	The MCO shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	2016 SIU Fraud, Waste, and Abuse Plan 20160322	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, pages 127-129	
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp;	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Credentialing and Recredentialing for Licensed Independent Practitioners Excluded Individuals and Entities - Prohibition on Hiring or Contracting_	Full	This requirement is met through the document: 2016 SIU Fraud, Waste, and Abuse Plan 20160322. Section 15. Fraud, Waste, and Abuse Prevention, page 127-128 Also met via the document: Credentialing and Recredentialing for Licensed Independent Practitioners page 25	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.dhh.la.gov/; and/or the System for Award Management, http://www.sam.gov . 25.13.2 The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).				
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual; Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care	2016 SIU Fraud, Waste, and Abuse Plan 20160322 Transplant Approval Policy - Solid Organ/BMT/Stem Cell	Full	This requirement is met through the documents: 2016 SIU Fraud, Waste, and Abuse Plan 20160322, page 122 The Transplant Approval Policy - Solid Organ/BMT/Stem Cell, page 5	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	services unless the MCO provides the appropriate surety bond.				