Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.3	**Behavioral Health Services**			
6.3.1	The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan.	Full	Addressed in Behavioral Health Continuity and Coordination of Care, Provider Handbook and Member Handbook.	
6.3.4	Basic Behavioral Health Services	N/A		
6.3.4.1	The CCN shall be responsible for providing basic behavioral health benefits and services to all members. Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, ARNP) as part of routine physician evaluation and management activities, and all behavioral health services provided at FQHCs/RHCs). The CCN shall	Full	Addressed in Behavioral Health Continuity and Coordination of Care. In an interview, the plan was asked to describe the kinds of screening tools used for basic behavioral health, such as the Patient Health Questionnaire (PHQ). The plan responded that the PHQ is available to providers on the Amerigroup website. PCPs have been notified of the posting. PCPs can make direct referrals to Magellan or if the PCP notifies Amerigroup regarding a member BH issue, the plan will make the referral. According to the plan, care managers screen and	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	utilize the screening tools and protocols approved by DHH. The CCN shall be required to work with PCPs to implement screening tools for basic behavioral health, such as the Patient Health Questionnaire, (PHQ-9) and the Pediatric Symptom Checklist (PSC, Y-PHC), which are subject to approval by DHH.		identify co-morbid BH conditions and refer to Magellan. In addition, Amerigroup coordinates care with Magellan through its BH CM Liaison.	
6.3.4.2	Basic behavioral health services/benefits shall include, but may not be limited to: Screening, Prevention and Referral - screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health.); behavioral health services provided in the member's PCP or medical office; outpatient non-psychiatric hospital services, based on medical necessity; and those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given episode of care. Medical services to be covered by the CCN include the following, but are not limited to: inpatient hospital services based on medical necessity, including: Acute Medical	Full	Addressed in Behavioral Health Continuity and Coordination of Care, Provider Handbook and Member Handbook.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Detoxification providing 24-hour availability of non-surgical medical treatment for acute intoxication and/or life threatening conditions, under the direction of a physician in a hospital or other suitably equipped medical setting, with continuous services to persons afflicted with an alcohol and/or drug related crisis. In addition to having a physician's direction, one registered nurse or one licensed practical nurse must be on duty 24 hours per day for every 10 patients.			
6.7	**Emergency Medical Services and Post Stabilization Services**			
6.7.1	Emergency Medical Services	N/A		
6.7.1.1	The CCN shall provide that emergency services be rendered without the requirement of prior authorization of any kind. The CCN must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the CCN. If an emergency medical condition exists, the CCN is obligated to pay for the emergency service.	Full	Addressed in Provider Handbook and Member Handbook.	
6.7.1.2	The CCN shall advise all Medicaid CCN members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Full	Addressed in Provider Handbook and Member Handbook.	
6.7.1.3	The CCN shall not refuse to cover emergency services based on the emergency room provider, hospital,	Full	Addressed in Provider Handbook and Member Handbook.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	or fiscal agent not notifying the member's PCP or CCN of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.		In an interview, the plan was asked whether there are any reasons for which the plan would refuse to cover emergency services. The plan responded that emergency services do not require pre-authorization and the 'prudent lay person' definition of an emergency is used by Amerigroup.	
6.7.1.4	The CCN shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Full	Addressed in Provider Handbook and Member Handbook.	
6.7.1.5	The CCN shall not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.	Full	Addressed in Provider Handbook and Member Handbook.	
6.7.1.6	The attending emergency physician 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 CCN for coverage and payment.	Substantial	The Member Handbook did not explicitly address that the attending emergency physician or provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the plan for coverage and payment. Recommendation: The Provider Handbook and Member Handbook should be revised to include this requirement.	MCO response: Plan will revise Provider handbook and member handbook to include requirement. IPRO response: No change in determination. Updated provider and member handbooks will be reviewed as part of next year's audit.
6.7.1.7	If there is a disagreement between a hospital or other treating facility and a CCN concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of	Substantial	The Provider Handbook and Member Handbook did not explicitly address the process if there is a disagreement between a hospital or other treating facility and a plan concerning whether the member is stable enough for discharge or transfer from the emergency room, that the judgment of the attending emergency physician at the hospital or other treating facility prevails and is binding to the plan.	MCO response: Plan will revise Provider handbook and member handbook to include requirement. IPRO response: No change in determination. Updated provider and member handbooks will be reviewed as part of next year's audit.

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	discharge or transfer prevails and is binding on the CCN. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.		Recommendation: The Provider Handbook and Member Handbook should be revised to include this requirement.	
6.7.1.8	The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	Full	Addressed in Provider Handbook and Member Handbook.	
6.7.1.9	The CCN shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies.	Full	Addressed in Member Handbook and Provider Handbook.	
6.7.1.10	The CCN shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency 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.	Full	Addressed in Member Handbook, Provider Handbook and Amerigroup Corporation Case Management Program Description.	
6.7.1.11	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.	Full	Addressed in Member Handbook.	
6.7.2	Post Stabilization Services	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.7.2.1	The CCN is financially responsible for post-stabilization care services obtained within or outside the CCN that are:	Full	Addressed in Member Handbook and Coverage for Post Stabilization Care Services.	
6.7.2.1.1	Pre-approved by a network provider or other CCN representative; or	Full	Addressed in Coverage for Post Stabilization Care services.	
6.7.2.1.2	Not preapproved by a network provider or other CCN representative, but:	Full	Addressed in Coverage for Post Stabilization Care Services	
6.7.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the CCN for pre-approval of further post-stabilization care services;	Full	Addressed in Coverage for Post Stabilization Care Services	
6.7.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the CCN: • Does not respond to a request for pre-approval within one (1) hour; • Cannot be contacted; or • CCN's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN 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 Section 6.7.2.1.4.1 (422.133(c)(3)) is met.	Full	Addressed in Member Handbook.	
6.7.2.1.3	The CCN's financial responsibility for post-stabilization care services that it has not pre-approved ends	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	when:			
6.7.2.1.3.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	Full	Addressed in Member Handbook.	
6.7.2.1.3.2	A network physician assumes responsibility for the member's care through transfer;	Full	Addressed in Member Handbook.	
6.7.2.1.3.3	A representative of the CCN and the treating physician reach an agreement concerning the member's care; or	Full	Addressed in Member Handbook.	
6.7.2.1.3.4	The member is discharged.	Full	Addressed in Member Handbook.	
6.16	**Medical Services for Special Populations**			
6.16.1	Special health care needs 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, requiring individualized health care approaches.	Full	Addressed in Special Needs Population Services-LA.	
6.16.2	The CCN shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). The PCP can identify members as having special needs at any time the member presents with those needs. The CCN must assess those members within ninety (90) days of identification. The assessment must be done by appropriate healthcare	Full	Addressed in Special Needs Population Services-LA.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management. During the initial phase-in implementation of the CCN Program, DHH will extend the identification timeframe requirement to 180 days from the enrollment effective date.			
6.16.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows:	N/A		
6.16.3.1	The CCN shall utilize Medicaid historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for SHCN criteria.	Full	Addressed in Special Needs Population Services-LA.	
6.16.3.2	The CCN PCPs shall identify to the CCN those members who meet SHCN criteria.	Full	Addressed in Special Needs Population Services-LA.	
6.16.3.3	Members may self identify to either the Enrollment Broker or the CCN that they have special health care needs. The Enrollment Broker will provide notification to the CCN of members who indicate they have special health care needs.	Full	Addressed in Special Needs Population Services-LA.	
6.16.4	Individualized Treatment Plans	N/A		
6.16.4.1	The individual treatment plans must be: developed by the member's PCP, with enrollee participation, and in consultation with any	Full	Addressed in Special Needs Population Services-LA and DMCCU Program Description 2013 Case Management File Review:	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	specialists caring for the member;		7 of 7 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning.	
6.16.4.2	Approved by the CCN in a timely manner if required by the CCN; and	Full	Addressed in DMCCU Program Description 2013	
6.16.4.3	In compliance with applicable QA and UM standards.	Full	Addressed in Case Management – LA and DMCCU Program Description 2013	
6.24	**Care Management**			
6.24.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, quality management, and independent review. The CCN shall ensure that each member has an ongoing source of primary care 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.	Full	Addressed in Case Management – LA, 2013 CM Program Description revised, Member Handbook and Provider Handbook.	
6.24.2	The CCN shall be responsible for ensuring:	N/A		
6.24.2.1	Member's health care needs and services/care are planned and coordinated through the CCN PCP;	Full	Addressed in Provider Handbook, Case Management – LA and Case Management Theory. (1_Intro_to_CM_ver1-1)	
6.24.2.2	Accessibility of services and promoting prevention through qualified medical home practices which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency	Full	Addressed in Coordination of Care-LA and Provider Handbook.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	medical conditions; and			
6.24.2.3	Care coordination and referral activities 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 and/or behavioral health services.	Full	Addressed in Coordination of Care-LA.	
6.25	**Referral System for Specialty Healthcare**			
6.25.1	The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The CCN shall provide the coordination necessary for referral of CCN members to specialty providers. The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.	Full	Addressed in Specialty Referral P&P and Standing Referrals –LA P&P.	
6.25.2	The CCN shall submit referral system policies and procedures for	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:			
6.25.2.1	When a referral from the member's PCP is and is not required;	Full	Addressed in Member Handbook.	
6.25.2.2	Process for member referral to an out-of-network provider when there is no provider within the CCN's provider network who has the appropriate training or expertise to meet the particular health needs of the member;	Full	Addressed in Specialty Referral P&P.	
6.25.2.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Full	Addressed in Standing Referrals –LA P&P.	
6.25.2.4	Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;	Full	Addressed in Standing Referrals –LA P&P and Specialty Referral P&P, Out of Area-Out of Network Care.	
6.25.2.5	Process for member referral for case management;	Full	Addressed in Case Management –L.A	
6.25.2.6	Process for member referral for chronic care management;	Full	Addressed in Case Management-LA.	
6.25.2.7	Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or	Full	Addressed in Prohibiting the Use of Financial Incentives When Making Necessity Determinations-Core Process.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	a member of the provider's family has a financial relationship.			
6.25.2.8	Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.	Full	Addressed in Medical Record Review-LA P&P,	
6.25.2.9	There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and	Full	Addressed in Specialty Referral P&P.	
6.25.2.10	Process for referral of members for Medicaid State Plan services that are excluded from CCN core benefits and services and that will continue to be provided through fee-for-service Medicaid.	Full	Addressed in Non-Covered and Cost Effective Alternative Services and Member Handbook.	
6.25.2.11	DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems.	N/A		
6.26	**Care Coordination, Continuity of Care, and Care Transition**			
6.26.1	The CCN 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 CCN members. The CCN shall establish a process to coordinate the delivery of core benefits and services with services that are	Full	Addressed in Coordination of Care LA 12-20-12	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	reimbursed on a fee-for-service basis by DHH. The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.			
6.26.2	The CCN shall be responsible for the coordination and continuity of care of healthcare services for all members.	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3	The CCN shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:	N/A		
6.26.3.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.2	Coordinate care between PCPs and specialists;	Full	Addressed in Coordination of Care LA 12-20-12	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.26.3.3	Coordinate care for out-of-network services, including specialty care services;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.4	Coordinate CCN provided services with services the member may receive from other health care providers;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.5	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;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, and other applicable state or federal laws;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.9	Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCP and/or appropriate specialists;	Full	Addressed in Coordination of Care LA 12-20-12	
6.26.3.10	Document authorized referrals in its utilization management system;	Full	Addressed in 2013 CM Program Description Revised 4/23/13	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.26.3.11	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 CCN. The CCN 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.	Full	Addressed in Continuity of Care-Core Process.	
6.30	**Continuity for Behavioral Health Care**			
6.30.1	The PCP shall provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.30.2	In order to ensure continuity and coordination of care for members who appear to need specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system or other managed care arrangement responsible for specialized behavioral health services (as applicable) for services.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.30.3	In any instance when the member presents to the network provider, including calling the CCN's toll-free number listed on the Member's ID	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	card, and a member is in need of emergency behavioral health services, the CCN shall instruct the member to seek help from the nearest emergency medical provider. The CCN shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. Payment for the emergency service is the responsibility of the CCN.			
6.30.4	The CCN shall comply with all post stabilization care service requirements.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.30.5	The CCN shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.30.6	The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.30.7	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 provides, facilities and agencies and require complex coordination of benefits and	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	services.			
6.30.8	The CCN shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	Full	Addressed in Behavioral Health Continuity and Coordination of Care-La.	
6.32	**Care Transition**			
6.32.1	Provide active assistance to members when transitioning to another provider (CCN, or Medicaid FFS).	Full	Addressed in Continuity of Care - Core Process.	
6.32.2	The receiving CCN shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this transition period, the receiving CCN shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.	Full	Addressed in Continuity of Care-Core Process	
6.32.3	If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify	Substantial	The Continuity of Care - Core Process did not explicitly address that the plan shall notify the receiving plan of the member's hospitalization status within 5 business days of the beginning of the month that the new plan member enrollment is effective.	MCO response: Plan will include this process in the Policy and Procedure. IPRO response: No change in determination. Updated policy will be

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the receiving CCN of the member's hospitalization status within five (5) business days of the beginning of the month that the new CCN member enrollment is effective.		Recommendation: The Continuity of Care- Core Process should be revised to include this requirement.	reviewed as part of next year's audit.
6.32.4	Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.	Full	Addressed in Continuity of Care-Core Process.	
6.32.5	Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.	Full	Addressed in Continuity of Care-Core Process and Coordination of Care – LA	
6.32.6	The CCN shall designate a person	Full	Addressed in Continuity of Care-Core Process and	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the DHH Medicaid Coordinated Care Section staff and staff from other CCNs to ensure a safe and orderly transition.		Coordination of Care – LA	
6.32.8	Special consideration should be given to, but not limited to, the following:	N/A		
6.32.8.1	Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;	Full	Addressed in Continuity of Care - Core Process.	
6.32.8.2	Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;	Full	Addressed in Continuity of Care - Core Process.	
6.32.8.3	Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;	Full	Addressed in Continuity of Care - Core Process.	
6.32.8.4	Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;	Full	Addressed in Continuity of Care - Core Process.	
6.32.9	When relinquishing members, the	Full	Addressed in Continuity of Care - Core Process.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN is responsible for timely notification to the receiving CCN regarding pertinent information related to any special needs of transitioning members. The CCN, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with CCN and service information, emergency numbers and instructions on how to obtain services.			
6.33	**Case Management (CM)**			
6.33.1	The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, social services, and basic behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member. The CCN shall submit case management program policies and procedures to DHH for	Full	Addressed in Case Management –LA. When asked during an interview conference call about how often the Case Management policies and procedures are submitted to the DHH, the plan responded that they are submitted as required by DHH and any time there is a revision.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	approval within thirty (30) days following the date the contract is signed and annually thereafter.			
6.33.2	Case Management program functions shall include but not be limited to:	N/A		
6.33.2.1	Early identification of members who have or may have special needs;	Full	Addressed in Case Management –LA.	
6.33.2.2	Assessment of a member's risk factors;	Full	Addressed in Case Management –LA. Case Management File Review: 3 of 3 case management files reviewed contained documentation of an assessment of the member's risk factors.	
6.33.2.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Full	Addressed in Case Management –LA.	
6.33.2.4	Development of an individualized treatment plan which must be: developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member, approved by the CCN in a timely manner if required by the CCN; and In compliance with applicable QA and UM standards;	Full	Addressed in Case Management –LA. Case Management File Review: 7 of 7 case management files reviewed contained an individualized treatment plan based on the needs assessment. 7 of 7 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning. 3 of 3 case management files reviewed contained an individualized treatment plan based on documentation of short and long term treatment objectives. Note that post Emergency Department/Inpatient encounter stabilization cases have only 30-day short	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			term goals.	
6.33.2.5	Referrals and assistance to ensure timely access to providers;	Full	Addressed in Case Management –LA. Case Management File Review: 8 of 8 case management files reviewed contained documentation of care coordination that actively links the member to providers and medical services.	
6.33.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Full	Addressed in Case Management –LA. Case Management File Review: 8 of 8 case management files reviewed contained documentation of care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed.	
6.33.2.7	Monitoring;	Full	Addressed in Case Management –LA. Case Management File Review: 4 of 4 case management files reviewed contained documentation of monitoring of outcomes. 1 of 1 case management files reviewed contained documentation of revision of the treatment plan as necessary.	
6.33.2.8	Continuity of care; and	Full	Addressed in Case Management –LA. Case Management File Review: 8 of 8 case management files reviewed contained documentation of care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed. 1 of 1 case management files reviewed contained documentation of coordination with the Chronic Care Management Program, as applicable.	
6.33.2.9	Follow-up and documentation.	Full	Addressed in Case Management –LA.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Case Management File Review: 4 of 4 case management files reviewed contained documentation of monitoring of outcomes. 1 of 1 case management files reviewed contained documentation of revision of the treatment plan as necessary.	
6.34	**Case Management (CM) Policies and Procedures**			
6.34.0	The CCN shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the CCN, annually and previous to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	Full	Addressed in 2013 CM Program Description Revised	
6.34.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Full	Addressed in 2013 CM Program Description Revised	
6.34.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Full	Addressed in 2013 CM Program Description Revised	
6.34.3	The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are	Full	Addressed in 2013 CM Program Description Revised	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the CCN's members; Procedures must describe collaboration processes with member's treatment providers;			
6.34.4	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Full	2013 CM Program Description Revised Case Management File Review: 8 of 8 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning.	
6.34.5	Procedures and criteria for making referrals to specialists and subspecialists;	Full	2013 CM Program Description Revised	
6.34.6	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and	Full	2013 CM Program Description Revised	
6.34.7	Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.	Full	2013 CM Program Description Revised Case Management File Review: 1 of 1 case management files reviewed contained documentation of coordination with the chronic care management program, as applicable.	
6.35	**Case Management Reporting Requirements**			
6.35.0	The CCN 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 CCN of additional required reports no	Full	AMG PQ 039 Case Management Report When asked in an interview conference call about how often the Case Management reports are submitted to the DHH, the plan responded that Report PQ039 is submitted quarterly through Amerigroup's regulatory compliance department.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:			
6.35.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	Full	Addressed in AMG PQ 039 Case Management Report	
6.35.2	Number of members with special healthcare needs identified by the member's PCP;	Full	Addressed in AMG PQ 039 Case Management Report	
6.35.3	Number of members with assessments;	Full	Addressed in AMG PQ 039 Case Management Report	
6.35.4	Number of treatment plans completed, and	Full	Addressed in AMG PQ 039 Case Management Report	
6.35.5	Number of members with assessments resulting in a referral for Case Management.	Full	Addressed in AMG PQ 039 Case Management Report	
6.36	**Chronic Care Management Program (CCMP)**			
6.36.1	The CCN shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Diabetes; and Congestive heart failure.	Full	Addressed in Congestive Heart Failure Disease Management (DM) Program	
6.36.2	The CCN 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; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include	Full	Addressed in Chronic Obstructive Pulmonary Disease Management (DM) Program	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.			
6.36.3	The CCN 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 CCN shall develop and implement policies and procedures that:	N/A		
6.36.3.1	Include the definition of the target population;	Full	Addressed in : Asthma Disease Management Program Chronic Destructive Pulmonary Disease	
6.36.3.2	Include member identification strategies;	Full	Addressed in Disease Management (DM) Program Member Identification.	
6.36.3.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Full	Addressed in Disease Management (DM) Program Member Identification and Disease Management Programs.	
6.36.3.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management	
6.36.3.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management	
6.36.3.6	Include methods for informing and educating members and providers;	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management	
6.36.3.7	Emphasize exacerbation and	Full	Addressed in Disease Management (DM) Programs and	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;		Disease Management (DM) Programs, Diabetes Disease Management	
6.36.3.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management	
6.36.3.9	Address co-morbidities through a whole-person approach;	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management Passive Chronic Care Management File Review: Documentation of addressing co-morbidities – this review was not applicable to the passive CCMP files reviewed. Active Chronic Care Management File Review: 5 of 5 chronic care management files reviewed contained documentation of addressing co-morbidities.	
6.36.3.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management Passive Chronic Care Management File Review: Treatment plan with interventions related to the member's chronic condition – this review was not applicable to the passive CCMP files. 16 of 16 chronic care management files reviewed contained documentation of the member's risk stratification level. Documentation of empowering the member to effectively manage disease and prevent exacerbation and complications – this review was not applicable to the passive CCMP files.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Documentation of coordination with the case management program – this review was not applicable to the passive CCMP files. Active Chronic Care Management File Review: 5 of 5 chronic care management files reviewed contained a treatment plan with interventions related to the member's chronic condition. 5 of 5 chronic care management files reviewed contained documentation of the member's risk stratification level. 5 of 5 chronic care management files reviewed contained documentation of empowering the member to effectively manage disease and prevent exacerbation and complications. Documentation of coordination with the case management – this review was not applicable to any of the 5 active CCMP files reviewed.	
6.36.3.11	Include Program Evaluation requirements.	Full	Addressed in Disease Management (DM) Programs and Disease Management (DM) Programs, Diabetes Disease Management	
6.37	**Predictive Modeling**			
6.37.1	The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.37.2	The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	but are not limited to:			
6.37.2.1	A brief history of the tool's development and historical and current uses;	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.37.2.2	Medicaid data elements to be used for predictors and dependent measure(s);	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.37.2.3	Assessments of data reliability and model validity;	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.37.2.4	A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.37.2.5	A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.	Full	Addressed in CM Program Description Revised and C13 Logic Documents for External Review.	
6.38	**CCMP Reporting Requirements**			
6.38.1	The CCN shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.	Full	Addressed in: AMG PQ042 CCMP Summary Report 2012 Q1 AMG PQ042 CCMP Summary Report 2012 Q2 AMG PQ042 CCMP Summary Report 2012 Q3 AMG PQ042 Chronic Care Management Program Report 2012 Q4 V2	
6.38.2	The CCMP reports shall contain at a minimum:	N/A		
6.38.2.1	Total number of members;	Full	Addressed in: AMG PQ042 CCMP Summary Report 2012 Q1 AMG PQ042 CCMP Summary Report 2012 Q2 AMG PQ042 CCMP Summary Report 2012 Q3 AMG PQ042 Chronic Care Management Program	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Report 2012 Q4 V2	
6.38.2.2	Number of members in each stratification level for each chronic condition; and	Full	Addressed in: AMG PQ042 CCMP Summary Report 2012 Q1 AMG PQ042 CCMP Summary Report 2012 Q2 AMG PQ042 CCMP Summary Report 2012 Q3 AMG PQ042 Chronic Care Management Program Report 2012 Q4 V2	
6.38.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	Full	Addressed in: AMG PQ042 CCMP Summary Report 2012 Q1 AMG PQ042 CCMP Summary Report 2012 Q2 AMG PQ042 CCMP Summary Report 2012 Q3 AMG PQ042 Chronic Care Management Program Report 2012 Q4 V2	
6.38.3	The CCN shall submit the following report annually:	N/A		
6.38.3.1	Program evaluation.	Full	Addressed in: AMG PQ042 CCMP Summary Report 2012 Q1 AMG PQ042 CCMP Summary Report 2012 Q2 AMG PQ042 CCMP Summary Report 2012 Q3 AMG PQ042 Chronic Care Management Program Report 2012 Q4 V2	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1	**General Provider Network Requirements**			
7.1.1	The CCN must maintain a network of qualified providers in sufficient numbers and locations within the GSA, including parishes contiguous to the GSA, to provide required access to covered services. The CCN is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the CCN's member population. The CCN shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, eliminates preventable hospital readmissions, and hospitalization for preventable medical problems.	Full	The plan submitted their Network Development and Management plan which meets this requirement; however, it only contains contract requirements in 7.8. It would be helpful if the plan developed a Network Development and Management P/P which contains all of the contract requirements relating to Provider Network. The plan provided evidence to show that their members have sufficient access to services, and where there are gaps, Amerigroup's Network Development Plan addresses.	
7.1.2	The CCN must provide a comprehensive network to ensure its membership has access at least equal to, or better, than community norms. Services shall be accessible to CCN	Full	The plan submitted their Network Development and Management plan, which meets this requirement; however, it only contains contract requirements in 7.8. It would be helpful if the plan developed a Network Development and Management P/P, which contains all of the contract requirements relating to Provider	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients within the same GSA who are not enrolled in the CCN Program. The CCN is encouraged to have available non-emergent after-hours physician or primary care services within its network. If the network is unable to provide medically necessary services required under contract, the CCN shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The CCN shall ensure coordination with respect to authorization and payment issues in these circumstances.		Network. The plan provided evidence to show that their members have sufficient access to services, and where there are gaps, Amerigroup's Network Development Plan addresses.	
7.1.3	There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis.	Full	P. 14 of the Provider Handbook meets this requirement. It states, "Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup." The Member's Rights section state that members have the right to "Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care."	
7.1.4	The proposed network shall be sufficient to provide core benefits and services within designated time	Full	P/P Default Standards and Measures for Determining Appropriate Accessibility to Care – LA meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	and distance limits.		The plan's GeoAccess reports show that the plan has contracted with providers and specialists to ensure sufficient access for their members within designated time and distance limits.	
7.1.5	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Full	The Americans with Disabilities Act Compliance for Participating Providers P/P meets this requirement.	
7.1.6	If a current Medicaid provider requests participation in a CCN, the CCN shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the CCN, the CCN has met this requirement; the CCN shall maintain documentation detailing efforts made.	Full	P.4 of the Network Development Plan states, "We will make good faith efforts to execute a contract with any current Medicaid provider who request participation. In the event an agreement cannot be reached and the provider does not participate in our network, Amerigroup will document outreach efforts in our SalesForce application."	
7.1.7	The CCN shall not discriminate with respect to participation in the CCN program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification. In addition, the CCN must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.	Full	P. 4 of the Network Development Plan: "Additionally, Amerigroup Louisiana will not discriminate with respect to participation in the 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)]." P.21 of the Provider Handbook (Provider Bill of Rights): "Be free from discrimination where Amerigroup selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment."	
7.1.8	The provision in 7.1.6 above does not prohibit the CCN from limiting provider participation to the extent necessary to meet the needs of the	Full	P. 4 of the Network Development Plan meets this requirement: "We recognize that we may limit provider participation to the extent necessary to meet the needs of our	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN's members. This provision also does not interfere with measures established by the CCN to control costs and quality consistent with its responsibilities under this contract nor does it preclude the CCN 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.		members. In certain circumstances, we may 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)]. If we decline participation of any provider, Amerigroup Louisiana will issue written notice of the reason for our decision within fourteen (14) calendar days of our decision [42 CFR 438.12(a)(1)]."	
7.1.9	The CCN 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 CCN, the CCN shall maintain documentation detailing efforts that were made.	Full	P. 4 of the Network Development Plan meets this requirement.	
7.1.10	The CCN must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs) in the GSA; all small rural hospitals in the GSA 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); and Louisiana State University safety net hospitals.	Full	P. 4 of the Network Development Plan meets this requirement.	
7.1.11	If the CCN declines requests of individuals or groups of providers to	Full	P. 4 of the Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	be included in the CCN network, the CCN must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.			
7.1.12	If the CCN terminates a provider's contract for cause, the CCN shall provide immediate written notice to the provider. The CCN 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.	Full	Provider/subcontractor contracts (Items 9.2 and 9.3) meet this requirement.	
7.1.13	The CCN 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 CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider.	Full	P. 6 of the Continuity of Care - Core Process P/P meets this requirement.	
7.1.15	The CCN shall meet the following requirements:	N/A		
7.1.15.1	Ensure the provision of all core benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this RFP. These minimum	Full	The plan also has a Physician Access P/P, which contains the plan's appointment standards, and the Default Standards and Measures for Determining Appropriate Accessibility to Care – LA P/P, which contains their network capacity and time/distance standards. The plan submitted GeoAccess reports to show that	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	requirements are not intended to release the CCN from the requirement to provide or arrange for the provision of any medically necessary covered benefit/service required by its members, whether specified or not.		their members have adequate access to services, and where there are gaps; Amerigroup's Network Development Plan addresses them.	
7.1.15.2	Provide core services directly or enter into written agreements with providers or organizations that shall provide core services to the members in exchange for payment by the CCN for services rendered. CCN in and out-of-network providers shall be eligible to enroll as Louisiana Medicaid providers.	Full	Copies of signed written agreements with providers were submitted which meets this requirement.	
7.1.15.3	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/search.aspx and www.EPLS.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	Full	P. 16 of the Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	
7.1.15.4	Ensure that CCN PCP's maintain hospital admitting privileges or that they have arrangements with a physician who has admitting	Full	P.66 of the Provider Handbook states "Hospital Affiliations and Privileges: Network providers must have clinical privileges, as appropriate to their scope of practice, in good standing at an Amerigroup network	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	privileges at a CCN participating hospital.		hospital." P.13 of the Cred/Recred policy states "e) Clinical Privileges - MD's and DO's must hold and maintain unrestricted clinical privileges at an Amerigroup participating hospital within their specialty…"	
7.1.15.5	Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Members health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered; information the member needs in order to decide among all relevant treatment options; the risk, benefits, and consequences of treatment and non-treatment; or the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	Full	P. 21 of the Provider Handbook (Provider Bill of Rights) meets this requirement.	
7.1.15.6	If the CCN is unable to meet the geographic access standards for a member, the CCN must make transportation available to the member, regardless of whether the member has access to transportation.	Full	P.7 of the Network Development Plan meets this requirement.	
7.1.15.7	Monitor provider compliance with applicable access requirements, including but not limited to,	Full	According to the Network Development Plan, "Amerigroup will respond to any changes in enrollment and/or the composition of our Provider network by	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appointment and wait times, and take corrective action for failure to comply. The CCN shall conduct service area review of appointment availability and twenty-four (24) hour access and availability surveys annually. The survey results must be kept on file and be readily available for review by DHH upon request.		diligent monitoring of capacity, network access, appointment availability, and Provider compliance with after-hours coverage." P.8 of the Network Development Plan details how the plan will use the deficiencies observed from the monitoring activities to develop and implement corrective action plans for non compliant providers.	
7.1.15.8	If a member requests a CCN provider who is located beyond access standards, and the CCN has an appropriate provider within the CCN who accepts new patients, it shall not be considered a violation of the access requirements for the CCN to grant the member's request. However, in such cases the CCN shall not be responsible for providing transportation for the member to access care from this selected provider, and the CCN shall notify the member in writing as to whether or not the CCN will provide transportation to seek care from the requested provider.	Substantial	The Network Development Plan partially meets this requirement. It states that Amerigroup will refer members to non-participating providers for care via a single care agreement, as needed. Furthermore, they would facilitate out of network care when a member's needs cannot be met within the network. There is no mention of who is responsible for providing transportation in these cases.	MCO response: Plan will be responsible for providing transportation for the member if Out of Network services cannot be provided in network. This will be incorporated in the Network Development Plan. IPRO response: No change in determination. Updated Network Development Plan will be reviewed as part of next year's audit.
7.1.15.9	The CCN 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 interpreters.	Full	P. 12 of the Provider Handbook meets this requirement. It states that the provider has the responsibility to "Providing services ethically and legally and in a culturally competent manner." In addition, it states the provider should "make provisions to communicate in the language or fashion primarily used by the member; contact our customer care center for help with oral translation services if needed.'	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.15.10	The CCN shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in monetary penalties up to $5,000 per day against the CCN.	Full	P.12 of the Provider Handbook states "Service model visits address provider education on policies and programs, including any changes as appropriate, as well as review of provider information (including provider demographics to validate accuracy of providers information in our systems and directories), and other key initiatives and topics, including but not limited to electronic support via provider website, panel listings, EDI/claims submission, quality initiatives, patient center medical home certification, and provider incentive programs."	
7.2	**Mainstreaming**			
7.2.1 [updated 9/8/11]	DHH considers mainstreaming of CCN members into the broader health delivery system to be important. The CCN therefore must ensure that all CCN providers accept members for treatment and that CCN providers do not intentionally segregate members in any way from other persons receiving services.	Full	P. 15 of the Provider Handbook states, "You may not use discriminatory practices such as: • Showing preference to other insured or private-pay patients • Maintaining separate waiting rooms • Maintaining appointment days • Denying or not providing to a member any covered service or availability of a facility • Providing to a member any covered service that 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"	
7.2.2	To ensure mainstreaming of members, the CCN 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	Full	P.37 of the Provider Handbook, under Member Rights it states that members have the right to "Be free from discrimination and receive covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated" P. 50 of the Member Handbook also states, "Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	include, but are not limited to, the following:		federal law, regardless of gender, race, age, religion, national origin, physical or mental disability or type of illness or condition."	
7.2.2.1	Denying or not providing to a member any covered service or availability of a facility.	Full	P. 15 of the Provider Handbook meets this requirement.	
7.2.2.2	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.	Full	P. 15 of the Provider Handbook meets this requirement.	
7.2.2.3	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.	Full	P. 15 of the Provider Handbook meets this requirement.	
7.2.3	If the CCN knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than the contract), DHH shall consider the CCN to have breached the provisions and requirements of the contract. In addition, if the CCN becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) calendar days, DHH shall consider the CCN to have breached the provisions and requirements of	Minimal	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and other relevant documentation.	MCO response: Plan will include this contract language in a related Policy and Procedures. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the contract.			
7.3	**Access Standards and Guidelines**			
7.3	The CCN shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. DHH will monitor the CCN's service accessibility. The CCN shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional, allied and para-medical personnel for the provision of core benefits and services, including all emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:	Full	P. 15 of the Provider Handbook states "We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members." P. 14 of the Provider Handbook (2.6. PCP Access and Availability) meets this requirement. The Network Development Plan meets this requirement.	
7.3.1	Twenty-four (24) Hour Coverage: The CCN shall ensure that all emergency medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct CCN members on where to receive emergency and urgent health care.	Full	P. 5 of the Provider Network states "To ensure all Members have access to primary care services for routine, urgent, and emergency services, our policies and procedures, Provider Agreement, and Provider Manual require that all primary care physicians (PCPs) must be accessible 24 hours a day, seven days a week (24/7) personally or through covered arrangements with a designated, contracted PCP." P.14 of the Provider Handbook (PCP Onsite Availability) meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	The CCN may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. Any triage system arrangement must be prior approved by DHH.		P.33 of the Provider Handbook provides information about Amerigroup On Call, which is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a registered nurse who can help them: • Find doctors when your office is closed, whether after hours or on weekends • Schedule appointments with you or other network doctors • Get to urgent care centers or walk-in clinics • Speak directly with a doctor or a member of the doctor's staff to talk about their health care needs P.8 of the Network Development Plan states "In rural and underserved areas, we may utilize telemedicine capabilities. Additionally, our Amerigroup On Call program provides a level of service beyond that of a typical nurse advice line, specifically 24/7 access for members to speak with nurses to provide triage services, self care advice, and assistance with referrals to network providers, including scheduling telephonic consultations with physicians." During the interviews, the Network Management team disclosed that currently, the Telemedicine is not being used extensively but it is a service that is available to providers if needed for their members.	
7.3.2	Travel Time and Distance: The CCN shall comply with the following maximum travel time and/or distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval.	Full	P.2 of the Network Development Plan states that Amerigroup determines geographic adequacy for our CCN network against the specified standards for time and distance from the member's residence to the PCP, member-to-provider ratios, provider capacity, and other special needs criteria that are specified in sections 7.3 through 7.7 of the CCP contract. P. 6 of the Network Development Plan has a section on Addressing Deficiencies When Provider Network is	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Unable to provide Appropriate Access. The plan has had to file an exception with the DHH for Plaquemines Parish because of a lack of providers in this area. The plan is continuously working on contracting with out-of-network providers for their members in this parish.	
7.3.2.1	Time and Distance to 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	Full	Default Standards and Measures for Determining Appropriate Accessibility to Care P/P meets this requirement. GeoAccess reports show that members have adequate access to PCPs.	
7.3.2.2	Time and Distance to Hospitals. For urban areas, within thirty (30) minutes of a member's residence. For rural areas, within thirty (30) miles. If no hospital is available within thirty (30) miles of a member's residence, the CCN may request, in writing, an exception to this requirement.	Full	Default Standards and Measures for Determining Appropriate Accessibility to Care P/P meets this requirement. GeoAccess reports show that members have adequate access to hospitals.	
7.3.2.3	Time and Distance to Specialists. Travel distance shall not exceed sixty (60) miles for at least 75% of members. Travel distance shall not exceed ninety (90) miles for all members. Access standards to specialists that cannot be met may be satisfied utilizing telemedicine with prior DHH approval.	Full	The Default Standards and Measures for Determining Appropriate Accessibility to Care P/P meets this requirement. GeoAccess reports show that members have adequate access to specialists.	
7.3.2.4	Time and Distance to Lab and Radiology Services. Travel distance shall not exceed thirty (30) minutes or thirty (30) miles. For rural areas,	Full	Default Standards and Measures for Determining Appropriate Accessibility to Care P/P meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	exceptions for community standards shall be justified, documented and submitted to DHH for approval. Other medical service providers participating in the CCN's network also must be geographically accessible to CCN members as outlined in this RFP.		GeoAccess reports show that members have adequate access to Lab/Radiology services.	
7.4	**Scheduling/Appointment Waiting Times**			
7.4.1	The CCN shall ensure that its network providers have an appointment system for core benefits and services and/or expanded services which are in accordance with prevailing medical community standards as specified below.	Full	P. 5 of the Network Development Plan states that Amerigroup routinely monitors Provider adherence to appointment standards through trending of Member and Provider complaint data. Such monitoring is performed through an annual audit of a random, statistically valid sampling of PCP, OB/GYN, and behavioral health Providers and annual Member satisfaction surveys. P. 8 and P. 16 of the Provider Handbook contain the appointment standards for PCPs and Specialists, respectively. P. 17 of the Member Handbook contains the appointment standards.	
7.4.2	The CCN shall have policies and procedures for these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The CCN shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The CCN shall monitor compliance with appointment standards and shall have a corrective action plan when	Full	P. 61 of the Provider Handbook states that "We strongly encourage PCPs to provide evening and Saturday appointment access. To learn more about participating in the after-hours care program, please call your local Provider Relations representative." P. 8 and P. 16 of the Provider Handbook contain the appointment standards for PCPs and Specialists, respectively. P. 17 of the Member Handbook contains the appointment standards. P. 8 of the Network Development Plan details Steps Taken When a Provider Was Not Meeting Appointment Access Standards.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appointment standards are not met.		P. 5 of the Network Development Plan states that Amerigroup routinely monitors Provider adherence to appointment standards through trending of Member and Provider complaint data. Such monitoring is performed through an annual audit of a random, statistically valid sampling of PCP, OB/GYN, and behavioral health Providers and annual Member satisfaction surveys. The plan submitted the Physician Access P/P which details appointment standards and assessment of compliance to these standards. It is recommended that the PCP Access P/P is revised to include the following items: ❑ Methods for educating both providers and members about the appointment standards. ❑ Methods for monitoring standards. ❑ Follow-up for providers that are non-compliant, as part of monitoring. ❑ Corrective action plan.	
7.5	**Timely Access**			
7.5	The CCN shall ensure that medically necessary services are available on a timely basis, as follows:	N/A		
7.5.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Full	P. 14 of the Provider Handbook and P. 17 of the Member Handbook meet this requirement.	
7.5.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by	Full	P. 14 of the Provider Handbook and P. 17 of the Member Handbook meet this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the PCP or directed by the CCN through other arrangements.			
7.5.3	Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Full	P. 14 of the Provider Handbook and P. 17 of the Member Handbook meet this requirement.	
7.5.4	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the CCN mails the member's welcome packet: within their first trimester within fourteen (14) days; within the second trimester within seven (7) days; within their third trimester within three (3) days; high risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;	Substantial	P. 14 of the Provider Handbook and P. 18 of the Member Handbook meet this requirement; however, the plan should review the appointment standards in the PCP contract because it does not seem to be consistent with this requirement. Item 6.32 states "Care to Pregnant Women - Any unreasonable delay in providing care to a pregnant Covered Person seeking prenatal care will be considered a material breach of this Agreement."Unreasonable delay" in providing care for pregnant Covered Persons shall mean the following: (a) for Covered Persons in their first trimester of pregnancy, in excess of three (3) weeks from the date of the Covered Person's request for regular appointments and 48 hours from the date of the Covered Person's request for urgent care; and (b) For Covered Persons past their first trimester of pregnancy, on the day they are determined to be eligible a first prenatal care appointment shall occur no later than fifteen (15) calendar days from the day they are determined to be eligible."	MCO response: Plan will insure that appointment standards in the provider Handbook and Member Handbook are consistent with the contract language. IPRO response: No change in determination. Updated appointment standards as well as the provider and member handbooks will be reviewed as part of next year's audit to ensure that they are consistent.
7.5.5	Routine, non-urgent, or preventative care visits within six (6) weeks;	Full	P. 14 of the Provider Handbook and P. 17 of the Member Handbook meet this requirement.	
7.5.6	Specialty care consultation within one (1) month of referral or as clinically indicated;	Full	P. 16 of the Provider Handbook and P.17 of the Member Handbook meet this requirement.	

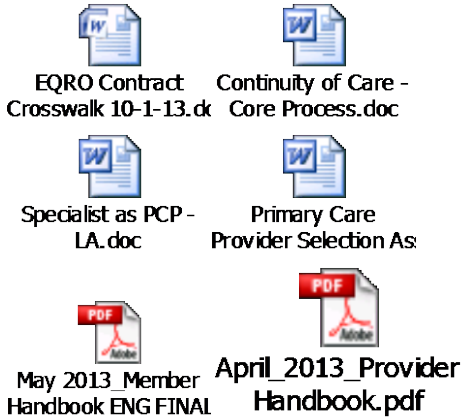
Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.5.7	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and	Full	P. 16 of the Provider Handbook and P.17 of the Member Handbook meet this requirement.	
7.5.8	Follow-up visits in accordance with ER attending provider discharge instructions.	Full	P. 17 of the Member Handbook meets this requirement. Recommendation: This requirement should be added to the Appointment Standards table in the Provider Handbook. The Appointment Standards table in the Provider Handbook, Member Handbook and the PCP Access P/P should be the same.	
7.5.9	In office waiting time for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room: Providers may be delayed when they "work in" urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (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	Substantial	P. 15 of the Provider Handbook meets this requirement. P. 18 of the Member Handbook meets this requirement. Amerigroup has an On Call program, which provides a toll-free, 24/7 access for members to speak with nurses to provide triage services, self care advice, and assistance with referrals to network providers, including scheduling telephonic consultations with physicians. The plan should review the appointment standards in the PCP contract because it does not seem to be consistent with this requirement. Item 6.5 states "Provider shall offer hours of operation that are no less than the hours of operation offered to patients with other insurance coverage, including but not limited to commercial health plans. If Provider is a primary care physician, Provider is encouraged to offer after-hours office care to Covered Persons on evenings	MCO response: Plan will update the all relevant documents to reflect the appropriate contract language and consistency with the contract. IPRO response: No change in determination. The updated PCP contract will be reviewed in conjunction with language in the provider and member handbooks to ensure they are consistent and meet the contract requirement.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.		and weekends. Provider shall use reasonable efforts to limit office wait times for appointments to one (1) hour or less," which is inconsistent with this requirement.	
7.5.10	The CCN shall monitor providers regularly to determine compliance with this Section through such methods as "mystery shopping" and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits; and take corrective action if there is a failure to comply.	Substantial	The plan monitors and carries out surveys to monitor compliance with access standards through a vendor. They have an Appointment Availability Survey and an After Hours survey. Appointment availability survey compliance: Total– 41% PCPs – 44% OB/Gyn – 28% Peds – 48% Waiting time survey compliance – PCPs – 67% OB/Gyn – 57% After hours survey compliance – Total – 71% PCPs – 71% OB/Gyn – 72% Peds – 69% The appointment availability survey and the waiting time survey compliance rates are low. During the interview, the plan stated that they are working on better educating providers about appointment standards through newsletters and onsite visits. It was recommended during the interview that the plan administer a re-survey of those providers found to be non-compliant after they have been given the corrective action plan, to assess whether they have	MCO response: Plan will develop and implement activities to address providers that are noncompliant with appointment availability and standards. The plan currently has implemented an action plan to address the Morpace findings. IPRO response: No change in determination. Plan actions to address providers that are non-compliant will be reviewed as part of next year's audit. The recommendation to resurvey non-complaint providers after the plan has educated them is reiterated.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			made changes to their internal systems to comply with appointment standards. The re-survey should be carried out in the interval between the annual surveys. It was also recommended that the plan adopt a mystery shopping methodology for the surveys, using the same scenarios currently being used. The After Hours survey methodology is adequate, but follow up calls are probably needed to non-compliant providers to ensure that they have made improvements as a result.	
7.5.11	The CCN must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization. The CCN is also encouraged to contract with or employ the services of non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.	Full	P. 7 of the Network Development Plan meets this requirement.	
7.5.12	The CCN shall establish processes to monitor and reduce the appointment "no-show" rate for PCPs, and transportation providers. As best practices are identified, DHH may require implementation by the CCN.	Full	P. 17 (2.14. Member Missed Appointments) of the Provider Handbook meets this requirement. During the interview, the plan explained that they monitor their transportation subcontractor daily (daily reports). They monitor provider "no show" rates but the onus is on the provider to report "no-shows" to the plan.	
7.5.13	The CCN shall have written policies and procedures about educating its provider network about appointment time requirements.	Full	P. 14 of the Provider Handbook contains the appointment standards as well at the PCP Access P/P. The Network Development Plan describes the	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	The CCN must develop a corrective action plan when appointment standards are not met. If appropriate, the corrective action plan should be developed in conjunction with the provider. Appointment standards shall be included in the Provider Manual. The CCN is encouraged to include the standards in the provider subcontracts.		corrective action taken when providers are not compliant with appointment standards. It also states that "Ongoing training will be supplied after initial start up by provider relations associates through provider orientation and periodic office visits. Documentation of provider training is maintained in the Provider Relations documentation system and can be viewed on the Provider Relations Monthly Activity report." It is recommended that the plan include appointment standards in the provider contracts as well.	
7.6	**Assurance of Adequate PCP Access and Capacity**			
7.6.1	The PCP shall serve as the member's initial and most important point of interaction with the CCN's provider network. A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.	Full	P. 12 of the Provider Handbook describes the role and responsibilities of the PCP.	
7.6.2	The PCP may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)) or outpatient clinic. The CCN shall provide at least one (1) full time equivalent (FTE) PCP per two thousand, five hundred (2,500) CCN members. DHH defines a full time PCP as a provider that provides primary care services for a	Full	Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity P/P meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	minimum of twenty (20) hours per week of practice time. The CCN shall require that each individual PCP shall not exceed a total of two thousand, five hundred (2,500) Medicaid linkages in all CCN's in which the PCP may be a network provider.			
7.6.2.1	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: Physician (Family Practice, General Practice, Internal Medicine, Pediatric, OB/GYN) – 1 : up to 2,500	Full	Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity P/P meets this requirement.	
7.6.2.2	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: Nurse Practitioner 1 : up to 1,000	Full	Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity P/P meets this requirement.	
7.6.2.3	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.	Full	Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity P/P meets this requirement.	
7.6.3	The CCN may submit a request for an exception to the PCP-to-patient ratio to DHH for approval.	N/A		
7.6.4	The CCN may, at its discretion, allow	Non-	This requirement was not addressed in any of the	MCO response:

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by the CCN) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP.	Compliance (Determination changed to Full, based on a re-review of submitted documents)	documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network, Primary Care Provider Selection, Assignment and Change Requests – LA P/P and any other relevant documentation.	Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. <u>P&Ps (Refer to Line 2 of Crosswalk and Line 2 of IPRO tool)</u> • Specialist as a PCP – LA • Continuity of Care – Core Process • Primary Care Provider Selection, Assignment and Change Requests – LA <u>Member Handbook</u> • Page 10 - Specialists <u>Provider Handbook</u> • Page 12 – 2.16  IPRO response: Based on a re-review of submitted documents, which indicate compliance with this standard, determination changed to “Full.”
7.6.5	The CCN shall provide access to primary care providers that offer	Substantial	The Provider Handbook states that PCPs are strongly encouraged to offer evening and Saturday	MCO response: Plan will amend provider handbook and any other

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer].		appointments for members. P.61 further states "We strongly encourage PCPs to provide evening and Saturday appointment access. To learn more about participating in the after-hours care program, please call your local Provider Relations representative." The Provider Handbook and other relevant documentation should clearly define what is expected in terms of "evening and Saturday" appointment for members, i.e. 2 hours at least one day per week after 5pm, and 4 hours or longer on Saturdays.	relevant plan documents to define what is expected for evening and Saturday appointments for the providers in our network. IPRO response: No change in determination. Updated provider handbook and documentation will be reviewed as part of next year's audit.
7.6.6	Network providers must offer office hours at least equal to those offered to the CCN's Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.	Substantial	The Provider Handbook states that network providers may not use discriminatory practices such as showing preference to other insured or private-pay patients. The documentation submitted does not mention office hours specifically. This language should be added to PCP Access P/P and other relevant P/P.	MCO response: Plan will amend Policy and Procedures to address provider office hours. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
7.6.7	The CCN shall identify and report to the Enrollment Broker, within seven (7) calendar days, any PCP approved to provide services under the contract that will not accept new patients or has reached capacity.	Non-Compliance	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity P/P and other relevant P/P or documentation.	MCO response: Plan will amend the following Policy and Procedure to address the stated concern P&Ps (Add text to reflect 7 calendar notification to Enrollment Broker) • Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity • Primary Care Provider Selection, Assignment and Change Requests – LA 9-6-12

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				Primary Care Provider Selection Asry Monitoring%20Prima%20Care%20Provi IPRO response: No change in determination. Updated policies will be reviewed as part of next year's audit.
7.7	**Primary Care Provider Responsibilities**			
7.7.0	PCP responsibilities shall include, but are not be limited to:	N/A		
7.7.1	Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;	Full	P. 12 of the Provider Handbook meets this requirement.	
7.7.2	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. Coordination shall include but not be limited to:	Full	P. 12 of the Provider Handbook meets this requirement.	
7.7.2.1	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; and	Full	P. 12 of the Provider Handbook meets this requirement.	
7.7.2.2	Communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and	Full	P. 12 of the Provider Handbook meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	follow up the care of individual patients.			
7.7.2.2.1	Provide the level of care and range of services necessary to meet the medical needs of its members, including those with special needs and chronic conditions,	Full	P. 12 of the Provider Handbook meets this requirement.	
7.7.2.2.2	Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS;	Full	P. 12 of the Provider Handbook meets this requirement, except for the following - "to include services available under Medicaid FFS;"	
7.7.2.2.3	Maintaining a medical record of all services rendered by the PCP and other referral providers; and	Full	P. 13 of the Provider Handbook meets this requirement.	
7.7.2.2.4	Coordinating case management services to include, but not be limited to, performing screening and assessment, development of plan of care to address risks and medical needs.	Full	P. 13 of the Provider Handbook meets this requirement.	
7.7.2.2.5	Coordinate the services the CCN furnishes to the member with the services the member receives from any another CCN during transition of care.	Full	P. 13 of the Provider Handbook meets this requirement.	
7.7.2.2.6	Share the results of identification and assessment of any member with special health care needs (as defined by DHH) with another CCN to which a member may be transitioning or has transitioned so that those activities need not be duplicated.	Full	P. 13 of the Provider Handbook meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.7.2.2.7	To ensure 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.	Full	P. 13 of the Provider Handbook meets this requirement.	
7.7.2.3	Examples of Acceptable PCP After-Hours Coverage: 1. The PCP's office telephone is answered after-hours by an answering service that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes. 2. The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable. 3. The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.	Full	P. 8 of the Provider Handbook meets this requirement.	
7.7.2.4	Examples of Unacceptable PCP After Hours Coverage: The PCP's office telephone is only answered during	Minimal	The plan only refers to acceptable PCP after hour coverage.	MCO response: Plan will add examples in the Provider Handbook as well as amend any relevant Policy and Procedures to

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	office hours. The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message. The PCP's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed. Returning after-hours calls outside of 30 minutes.		This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan give examples of unacceptable PCP after-hours coverage in the PCP Access P/P and Provider Handbook.	incorporate this information. IPRO response: Review determination is unchanged. Updated Provider Handbook and policies will be reviewed as part of next year's audit.
7.7.3	Access to Specialty Providers	N/A		
7.7.3.1	The CCN shall assure access to specialty providers, as appropriate, for all members. The CCN shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area. The CCN 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). The CCN shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	Full	GeoAccess reports show that the plan's members have sufficient access to specialists, and where there are gaps, Amerigroup's Network Development Plan addresses them.	
7.7.3.2	The CCN shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in	Full	GeoAccess reports show that the plan's members have sufficient access to specialists, and where there are gaps, Amerigroup's Network Development Plan addresses them.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: the CCN has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and the CCN is in compliance with access and availability requirements.			
7.7.3.3	The CCN shall assure, at a minimum, the availability of the following specialists and other providers, as appropriate for both adults and pediatric members, on at least a referral basis: See Provider Type check list at end of this document.	Full	GeoAccess reports show that the plan's members have sufficient access to specialists, and where there are gaps, Amerigroup's Network Development Plan addresses them.	
7.7.3.4	The CCN shall meet standards for timely access to all specialists and ensure that the number of CCN members per specialist does not exceed the following in each of the CCN's GSAs. The following provider/member ratios are the minimum the CCN must provide. The CCN 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 CCN does not meet the access standards (e.g. scheduling of appointment, timely	Full	The PCP Access P/P and Default Standards and Measures for Determining Appropriate Accessibility to Care – LA P/P meet this requirement. The plan's GeoAccess reports show that the plan has contracted with providers and specialists to ensure sufficient access for their members within designated time and distance limits.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	access, time and travel distance requirements) specified in the Contract. See Maximum Number of Members per Provider by Specialty at end of this document.			
7.7.4	Access to Home Health Agencies: the CCN shall comply with any applicable federal requirements with respect to home health agencies, as amended.	Minimal	GeoAccess reports were not available for Home Health Agencies. Home Health Agencies were not mentioned in the Network Development Plan.	MCO response: The plan will incorporate into the GeoAccess studies and Network Development Plan. IPRO response: Review determination is unchanged. Updated GeoAccess studies and Network Development Plan will be reviewed as part of next year's audit.
7.7.5	Access to Hospitals	N/A		
7.7.5.1	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.	Substantial (Based on re-review, review determination changed to "Full")	The plan submitted a copy of their signed contract with Christus Health Northern Louisiana, which states that providers "must be a certified Medicare and certified Medicaid Provider, to the extent required under the Programs." It is recommended that the plan include this contract language in P/Ps related to Provider Network and other relevant documentation.	MCO response: Plan disagrees with this review determination. Hospital services providers are required by contract languages to adhere to applicable state and federal laws and regulations. IPRO response: Based on a re-review of the hospital contract, which contains language that meets this requirement, determination is changed to "Full."
7.7.5.2	The CCN 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 GSA, provided the parish has such a hospital. Essential hospital services for: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and a	Substantial	The plan submitted GeoAccess reports to show that members have sufficient access to hospitals in urban and rural areas. There was no mention of the exact specifications of the hospital in any of the documentation received. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language in relevant Policy and Procedures. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Children's Hospital.			
7.7.5.3	The CCN may contract with out-of-state hospitals in the trade area.	Minimal	This requirement was not addressed in any of the documentation submitted by the plan. There was no mention of out of state hospitals in any of the documentation received. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language in relevant Policy and Procedures. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.5.4	The CCN may contract with out-of-state hospitals to comply with these requirements if there are no hospitals within the parish that meet these requirements or a contract cannot be negotiated.	Minimal	This requirement was not addressed in any of the documentation submitted by the plan. There was no mention of out of state hospitals in any of the documentation received. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language in relevant Policy and Procedure. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.6	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 CCN 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 in the GSA. If the CCN does not have a full range of tertiary care services, the CCN shall have a process for providing such services including transfer protocols and	Substantial	The plan submitted signed written agreements with facilities that provide tertiary care services. Tertiary care services and processes for providing access to such services were not mentioned in any P/P or the Network Development Plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and the Network Development Plan.	MCO response: Plan will include this contract language in Policy and Procedures related to the Provider Network and the Network Development Plan. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	arrangements with out-of-network providers.			
7.7.7	Direct Access to Women's Health Care - The CCN 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.	Substantial	GeoAccess reports show that members have sufficient access to Ob-Gyn practitioners, according the time/distance specifications in the contract. It is recommended that the plan include this contract language in P/Ps related to Provider Network and the Network Development Plan.	MCO response: Plan will include this contract language in the Policy and Procedure that is related to the Provider Network and the Network Developmental Plan. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.7.1	The CCN 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 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 CCN family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy.	Full	P. 25 of the Provider Handbook and p. 24 of the Member Handbook meet this requirement.	
7.7.7.2	CCN members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the CCN's provider network without any restrictions. CCN	Substantial	P. 25 of the Provider Handbook and p. 24 of the Member Handbook meet this requirement. Both documents should encourage members to choose family planning services within Amerigroup's network to ensure continuity and coordination of care.	MCO response: Plan will encourage members to choose family planning services within Amerigroup's network to ensure continuity and coordination of care. IPRO response:

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	members should be encouraged by the CCN to receive family planning services through the CCN's network of providers to ensure continuity and coordination of the member's total care.			Review determination is unchanged. The availability of family planning services should be encouraged and discussed in the Member and Provider Handbooks.
7.7.7.3	The CCN 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, and shall reimburse providers for all family planning services regardless of whether that provider is a network provider no less than the Medicaid fee-for-service rate on date of service.	Substantial	The Provider Handbooks states that family planning services are covered and do not require a referral or precertification. Members may choose a network or non-network provider. The documentation submitted does not mention contracting with "all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act". It is recommended that the plan include this contract language in P/Ps related to Provider Network and the Network Development Plan.	MCO response: Plan will incorporate this contract language in the Policy and Procedures that are related to Provide Network and the Network Developmental Plan. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.7.4	Reimbursement to out-of-network providers of family planning services for members shall be no less than the Medicaid fee-for-service rate on date of service. The CCN may require family planning providers to submit claims or reports in specified formats before reimbursing services.	Non-Compliance	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language to relevant documentation. P&Ps (add under LA Exception text regarding family planning 7.7.7.4) • Out of Area-Out of Network Care 10-18-12  Out-of-Service Area - Out-of-Network Car IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.7.5	The CCN shall maintain the confidentiality of family planning	Full	In p. 58 of the Member Handbook, the plan details its privacy practices, which covers maintaining the	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	information and records for each individual member including those of minor patients.		confidentiality of each member's medical information as a whole, without specifically mentioning family planning information. This is sufficient to meet this requirement.	
7.7.8	Prenatal Care Services	N/A		
7.7.8.1	The CCN shall have a sufficient number of providers to ensure that prenatal care services are not delayed or denied to pregnant women.	Full	The plan submitted GeoAccess reports to show that members have adequate access to Ob-Gyn providers in urban and rural areas.	
7.7.8.2	Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for Louisiana Medicaid. For women who are past their first trimester of pregnancy on the first day they are determined to be eligible, a first prenatal appointment shall be scheduled as required in 7.5.4.7.	Full	P. 14 of the Provider Handbook and P. 18 of the Member Handbook meet this requirement. The plan should check the appointment standards in the PCP contract because it does not seem to be consistent with this requirement. Item 6.32 states "6.32 Care to Pregnant Women - Any unreasonable delay in providing care to a pregnant Covered Person seeking prenatal care will be considered a material breach of this Agreement."Unreasonable delay" in providing care for pregnant Covered Persons shall mean the following: (a) for Covered Persons in their first trimester of pregnancy, in excess of three (3) weeks from the date of the Covered Person's request for regular appointments and 48 hours from the date of the Covered Person's request for urgent care; and (b) For Covered Persons past their first trimester of pregnancy, on the day they are determined to be eligible a first prenatal care appointment shall occur no later than fifteen (15) calendar days from the day they are determined to be eligible."	
7.7.8.3	All pregnant members should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of	Full	P. 17 of the Provider Handbook and P. 14 of the Member Handbook meet this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the CCN shall assign one. If the CCN was not aware that the member was pregnant until she presented for delivery, the CCN shall assign a pediatrician or a PCP to the newborn baby within one (1) business day after birth.			
7.7.9	Other Service Providers - The CCN 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.	Minimal (Based on re-review, determination changed to "Full")	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan disagrees with the review determination. The attached Policy and Procedures address the specific medical service providers.  Provider Network Accessibility Analysis  Specialty Referral.doc  Credentialing and Ongoing Assessment  Default Standards and Measures for Del IPRO response: Review determination changed to "Full," based on a re-review of plan policies. The plan meets this requirement. The plan has a credentialing policy, and access and availability policies that refer to "ancillary" providers or services, which includes other service providers, as referred to in this requirement.
7.7.10	Non-Emergency Medical Transportation - For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the CCN shall require	Full	P. 27 of the Provider Handbook states "Nonemergency transportation to and from a provider's office is covered."	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	its transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.			
7.7.11	FQHC/RHC Clinic Services	N/A		
7.7.11.1	The CCN must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the GSA and include them in its provider network.	Full	P. 4 of the Network Development Plan meets this requirement.	
7.7.11.2	If a CCN is unable to contract with an FQHC or RHC within the geographic service area and PCP time and distance travel standards, the CCN is not required to reimburse that FQHC or RHC for out-of-network services if FQHC or RHC services within Time and Distance to Primary Care Standards are available in that area unless: the medically necessary services are required to treat an emergency medical condition ; or FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the GSA within DHH's established time and distance travel standards.	Non-Compliance	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language in the Policy and Procedures. P &Ps (under LA Exception text regarding 7.7.11.2) • Out of Area-Out of Network Care 10-18-12  Out-of-Service Area - Out-of-Network Car IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.11.3	The CCN may stipulate that reimbursement will be contingent upon receiving a clean claim and all	Full	P. 76 of the Provider Handbook and P. 24 of the Member Handbook meet this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the medical records information required to update the member's medical records.			
7.7.11.4	While CCNs are not, in general, financially responsible for specialty behavioral health services, CCNs are responsible for all behavioral health services provided at FQHCs/RHCs.	Full	P. 76 of the Provider Handbook and P. 24 of the Member Handbook meet this requirement.	
7.7.11.5	The CCN shall inform members of these rights in their member handbooks.	Full	P. 24 of the Member Handbook meets this requirement.	
7.7.11.6	The CCN shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from DHH.	Full	P.4 of the Network Development Plan meets this requirement.	
7.7.12	School-Based Health Clinics (SBHCs)	N/A		
7.7.12.1	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.	N/A	Definition	
7.7.12.2	The CCN must offer a contract to each SBHC in their GSA. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures	Full	P. 4 of the Network Development Plan meets this requirement.	
7.7.13	Local Parish Health Clinics	N/A		
7.7.13.1	The CCN 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).	Full	P. 4 of the Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.7.13.2	The CCN 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 (Medicaid), and the CCN.	Substantial	This requirement was not addressed in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will include this contract language in the Policy and Procedures related to the Provider Network and any other relevant documentation. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.7.14	Significant Traditional Providers. The CCN shall make a good faith effort to include in its network significant traditional providers (STPs) in its GSA for the first two (2) years of operation under the CCN Contract provided that the STP: agrees to participate as an in-network provider and abide by the provisions of the provider contract; and meets the credentialing requirements. Provider types/classes eligible for participation as a STP are: Physicians, PCPs; OB-GYNs, and Hospitals.	Substantial	The Network Development Plan partially meets this requirement. It states, "We will make good faith efforts to execute contracts with significant traditional providers (STPs). In the event an agreement cannot be reached and the provider does not participate in our network, Amerigroup will document outreach efforts in our SalesForce application." This requirement was not addressed anywhere else in any of the documentation submitted by the plan. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan will include this contract language in Policy and Procedure related to Provider Network and any other relevant documentation. IPRO response: Review determination is unchanged. Updated policies will be reviewed as part of next year's audit.
7.8	**Network Provider Development Management Plan**			
7.8.1	The CCN shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core	Full	The Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	benefits and services will occur. The Network Development and Management Plan shall be submitted to DHH within thirty (30) days from the date the CCN signs to contract with DHH for evaluation and approval, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the CCN'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 CCN shall consider the following:			
7.8.1.1	Anticipated maximum number of Medicaid members;	Full	The Network Development Plan meets this requirement.	
7.8.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the CCN;	Full	The Network Development Plan meets this requirement.	
7.8.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Full	The Network Development Plan meets this requirement.	
7.8.1.4	The numbers of CCN providers who are not accepting new CCN members; and	Full	The Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.8.1.5	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.	Full	The Network Development Plan meets this requirement.	
7.8.2	The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and shall include:	Full	The Network Development Plan meets this requirement.	
7.8.2.1	Assurance of Adequate Capacity and Services	Full	The Network Development Plan meets this requirement.	
7.8.2.2	Access to Primary Care Providers	Full	The Network Development Plan meets this requirement.	
7.8.2.3	Access to Specialists	Full	The Network Development Plan meets this requirement.	
7.8.2.4	Access to Hospitals	Full	The Network Development Plan meets this requirement.	
7.8.2.5	Timely Access	Full	The Network Development Plan meets this requirement.	
7.8.2.6	Service Area	Full	The Network Development Plan meets this requirement.	
7.8.2.7	Other Access Requirements: Direct Access to Women's Health, Special Conditions for Prenatal Providers, Second Opinion and Out-of-	Full	The Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Network Providers.			
7.8.3	The Network Provider Development and Management Plan shall identify gaps in the CCN's provider network and describe the process by which the CCN shall assure all covered services are delivered to CCN members. Planned interventions to be taken to resolve such gaps shall also be included.	Full	The Network Development Plan meets this requirement.	
7.8.4	The CCN shall provide GEO mapping and coding of all network providers for each provider type to geographically demonstrate network capacity. The CCN shall provide updated GEO coding to DHH quarterly, or upon material change or upon request.	Full	The Network Development Plan meets this requirement.	
7.8.5	The CCN shall develop and implement Network Development policies and procedures detailing how the CCN will:	N/A		
7.8.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Full	The Network Development Plan meets this requirement.	
7.8.5.2	Monitor network compliance with policies and rules of DHH and the CCN, 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;	Full	The Network Development Plan meets this requirement.	
7.8.5.3	Evaluate the quality of services	Full	The Network Development Plan meets this	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	delivered by the network;		requirement.	
7.8.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Full	The Network Development Plan meets this requirement.	
7.8.5.5	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	Full	The Network Development Plan meets this requirement.	
7.8.5.6	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;	Full	The Network Development Plan meets this requirement.	
7.8.5.7	Provide training for its providers and maintain records of such training;	Full	The Network Development Plan meets this requirement.	
7.8.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Full	The Network Development Plan meets this requirement.	
7.8.5.9	Ensure that provider calls 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 CCN must document why the issue	Full	The Network Development Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	goes unresolved; however, the issue must be resolved within 90 days.			
7.8.6	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.	Full	The Network Development Plan meets this requirement.	
7.8.7	CCN Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	N/A	DHH Responsibility	
7.9	**Material Change to Provider Network**			
7.9.1	The CCN shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the CCN's provider network, whether terminated by the CCN 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 CCN's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:	Non-Compliance (based on a re-review of the policy, determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network, Provider	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1ai] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA  Timely Notification of Participating Provider

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Terminations, and any other relevant documentation.	IPRO response: Review determination changed to "Substantial." The plan policy states that Amerigroup must notify the DHH of a provider termination within 7 calendar days, and that the notification will include: 1."Notification to the DHH of Provider Termination Amerigroup Louisiana adheres to the following guidelines for notifying the DHH: • a) As soon as possible, but no later than seven (7) calendar days, of written notification of cancellation to the provider. • b) All received provider termination notices will be forwarded to the VP of Provider Relations and to the Regulatory Services Department. • c) The Regulatory Services Department will verify that the VP of Provider Relations has reviewed the termination and network adequacy to ensure the termination has not affected access standards. • i) Regulatory Services will submit notification of the provider termination to DHH within the timeframes outlined above." This policy also states that Amerigroup must notify the Enrollment broker within 1 day of provider termination/cancellation. However, the policy does not detail what should be included in the notification, i.e. • It does not include that reason(s) for the termination should be included in the notification. • It does not include the language in 7.9.1.1. • It does not include the language in 7.9.1.2. • It does not include the language in 7.9.1.3. • It does not include the language in 7.9.1.4. • It does not include the language in 7.9.1.5.
7.9.1.1	Any change that would cause more	Non-Compliance	This language was not found in any P/P submitted by	MCO response:

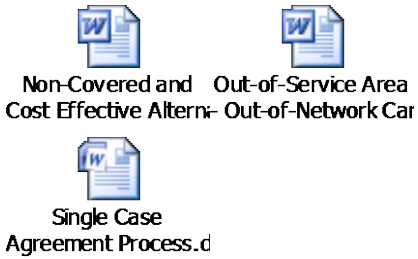
Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	than five percent (5%) of members in the GSA to change the location where services are received or rendered.	(based on a re-review of the policy, determination changed to "Substantial")	the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) was addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1aii1] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA  Timely Notification of Participating Provider IPRO response: Review determination changed to "Substantial." As noted above, the language governing this standard is not specifically included in the policy.
7.9.1.2	A decrease in the total of individual PCPs by more than five percent (5%);	Non-Compliance (based on a re-review of the policy, determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) was addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network.	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1aii2] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA  Timely Notification of Participating Provider

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	IPRO response: Review determination changed to "Substantial." As noted above, the language governing this standard is not specifically included in the policy.
7.9.1.3	A loss of any participating specialist which may impair or deny the members' adequate access to providers;	Non-Compliance (based on a re-review of the policy, determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1aii3] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA  Timely Notification of Participating Provider IPRO response: Review determination changed to "Substantial." As noted above, the language governing this standard is not specifically included in the policy.
7.9.1.4	A loss of a hospital in an area where another CCN hospital of equal service ability is not available as required by access standards specified in this RFP; or	Non-Compliance (based on a re-review of the policy, determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P,	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1aii4] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	 Timely Notification of Participating Provider IPRO response: Review determination changed to "Substantial." As noted above, the language governing this standard is not specifically included in the policy.
7.9.1.5	Other adverse changes to the composition of the CCN which impair or deny the members' adequate access to providers.	Non-Compliance (based on a re-review of the policy, determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps [under 1aii5] Crosswalk/IPRO FTP tool - Line 21 & 36 • Timely Notification of Participating Provider Termination – LA  Timely Notification of Participating Provider IPRO response: Review determination changed to "Substantial." As noted above, the language governing this standard is not specifically included in the policy.
7.9.2	The CCN 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	Non-Compliance (Determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan.	MCO response: The plan disagrees with the review determination. The embedded Policy and Procedure addresses this element. P&Ps • State Notification – Material Modifications to MCO/COA Applications

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	expanded services, payments, or eligibility of a new population.		During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	 State Notification - Material Modifications IPRO response: Based on a re-review of the plan's policy, review determination is changed to "Substantial." Page 3 of the above policy states: "In accordance with Louisiana Revised Statute 22:244(D)(1)-(2), the licensed health plan is to file a notice describing any material modification of the operation. A material modification is a change in any of the following: 1. A change of ten percent (10%) or more of the ownership of the health plan; 2. A reduction or expansion of twenty percent (20%) or more in the service area of the health plan; 3. A change in the evidence of coverage; 4. A change in the individual or group contract; 5. A change in reinsurance, stop loss or excess loss insurance or agreements; or 6. A change in the accreditation standing of the plan, or in the case of a plan which is in the process of being accredited, a change in the accreditation plan approved by the commissioner. Notice is to be filed with the Commissioner, Department of Insurance (DOI) prior to the modification. If the DOI does not disapprove the proposed modification within thirty (30) days, the modification is deemed approved." The policy Timely Notification of Participating Provider Termination states that the Regulatory Services Department will verify that the VP of Provider Relations has reviewed the termination and network adequacy to ensure the termination has not affected access

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				standards. Neither policy mentions that the plan is required "to submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services", as per the contract. In addition, material change in the contract is defined as a decrease in the total of individual PCPs by more than five percent (5%), which is not mentioned in either policy.
7.9.3	When the CCN has advance knowledge that a material change will occur, the CCN 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.	Non-Compliance (Determination changed to "Substantial")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan will incorporate the following contract language in the relevant Policy and Procedures. P&Ps (add text about request to DHH within 60 days prior to expected implementation provided to members for a material change in provider network including draft notification provided to members).   PCP%20Termination Timely Notification of %20Letters%20-%2Participating Provider Crosswalk/IPRO FTP tool - Line 21 & 36 IPRO response: Based on a re-review of the plan's policy, review determination is changed to "Substantial." The plan provided a sample letter to members informing them of a provider termination. The letters are dated 05/13/13 and the effective termination date of the providers in the letter is 7/5/13 (53 days difference). The policy above does not mention that any material change in the provider network must be approved by the DHH.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.9.4	The request must include a description of any short-term gaps indentified as a result of the change and the alternatives that will be used to fill them.	Non-Compliance	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: Plan will incorporate the following contract language into relevant Policy and Procedures. P&Ps (Crosswalk/IPRO FTP tool - Line 75) • Out of Area – Out of Network Care • Non-covered and Cost Effective Alternative Services (Line 2)  Non-Covered and Cost Effective Altern... Out-of-Service Area - Out-of-Network Car... Single Case Agreement Process.d... IPRO response: Review determination is unchanged. The updated policies will be reviewed as part of next year's audit.
7.9.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the CCN's provider network requires thirty (30) days advance written notice to affected members For emergency situations; DHH will expedite the approval process.	N/A		
7.9.6	The CCN shall notify the DHH/BHSF/Medicaid Coordinated Care Section within one (1) business day of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and	Non-Compliance (Determination changed to "Minimal")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan.	MCO response: The plan disagrees with the review determination of non-compliance. The P&P does address the timely notification. The plan will expand on the comment to reflect death, illness, etc. P&Ps (states notifying Enrollment Broker in 1 business day – expand to reflect death, illness, etc.) Crosswalk/IPRO FTP tool – Lines 21, 36, 44, and 66)

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	fails to notify the CCN, 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:		During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	• Provider Terminations – Primary Care Provider, Specialist and Hospital  Provider Terminations - Primar IPRO response: Based on a re-review of the plan's policy, the review determination is changed to "Minimal." Page 2 of the policy above states that "Health Plan will notify the Enrollment Broker by close of business the next business day of a PCP's termination." The policy does not mention that the plan must notify the DHH/BHSF/Medicaid Coordinated Care Section within 1 business day as well.
7.9.6.1	Information about how the provider network change will affect the delivery of covered services, and	Non-Compliance (Determination changed to "Full")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan disagrees with this review determination of the following non-compliance. The Policy and Procedure will be expanded to added contract language mentioned. P&Ps (expand text) • Continuity of Care • Timely Notification of Participating Provider Termination –LA 1-1-12   Continuity of Care - Core Process.doc Timely Notification of Participating Provider IPRO response: Based on a re-review of the plan's policies, the review determination is changed to "Full."

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				The plan has a policy in place to ensure continuity of care to minimize the impact of any network changes that occur as a result of provider terminations (Continuity of Care - Core Process). In p.2 of the policy "Timely Notification of Participating Provider Termination", it states that the Regulatory Services Department will verify that the VP of Provider Relations has reviewed the termination and network adequacy to ensure the termination has not affected access standards, as part of their notification to the DHH of provider termination.
7.9.6.2	The CCN's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	Non-Compliance (Determination changed to "Full")	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan disagrees with this review determination of the following non-compliance. The Policy and Procedure will be expanded to added contract language mentioned. P&Ps (expand text) Crosswalk/IPRO FTP tool – Lines 66 & 77 • Continuity of Care • Timely Notification of Participating Provider Termination –LA 1-1-12  Continuity of Care - Core Process.doc  Timely Notification of Participating Provider  Single Case Agreement Process.d IPRO response: Based on a re-review of the plan's policies, the review determination is changed to "Full."

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				The plan has a policy in place to ensure continuity of care to minimize the impact of any network changes that occur as a result of provider terminations (Continuity of Care - Core Process). In the policy "Timely Notification of Participating Provider Termination " the plan should mention that they have to include in their notification to the DHH a plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.
7.9.7	CCN's shall give hospitals and provider groups ninety (90) days notice prior to a contract termination without cause. Contracts between the CCN and single practitioners are exempt from this requirement.	Non-Compliance	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P. None of the requirements in this section (7.9) were addressed in any of the documentation submitted by the plan. During the interview, the plan stated that the Reporting Authority and Requirements P/P may contain the language that would meet this requirement. This P/P, although important, does not address Amerigroup's reporting responsibilities in relation to provider terminations and material change to the provider network. It is recommended that the plan include this contract language in P/Ps related to Provider Network and any other relevant documentation.	MCO response: The plan disagrees with this review determination of the following non-compliance. The Policy and Procedure will be expanded to added contract language mentioned. P&Ps (expand 2 C) (Line 66) • Delegate Terminations and De-delegations 4-18-13  Delegate Terminations and De- IPRO response: The review determination is unchanged. This contract language was not found in the policy provided above. The policy does not state that the plan must give hospitals 90 days notice prior to a contract termination without cause.
7.10	**Coordination with Other Service Providers**			
7.10	The CCN shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve	Full	P.35 of the Provider Handbook educates providers on other services under FFS.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).			
7.11	**Patient-Centered Medical Home (PCMH)**			
7.11.1	Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The CCN shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.	Full	The PCMH Implementation Plan meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.11.2	The CCN shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date that identifies the methodology for promoting and facilitating PPC®-PCMH recognition and/or JCAHO PCH accreditation. The implementation plan shall include, but not be limited to:	Full	The PCMH Implementation Plan meets this requirement.	
7.11.2.1	Payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain NCQA PPC®- PCMH recognition or JCAHO PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters;	Full	P.1 of the PCMH Implementation Plan meets this requirement.	
7.11.2.2	Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or JCAHO PCH accreditation(e.g., education, training, tools, and provision of data relevant to patient clinical care management);	Full	P.2 of the PCMH Implementation Plan meets this requirement.	
7.11.2.3	Facilitation of specialty provider network access and coordination to support the PCMH; and	Full	P.2 of the PCMH Implementation Plan meets this requirement.	
7.11.2.4	Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Full	P.4 of the PCMH Implementation Plan meets this requirement.	
7.11.3	The CCN shall meet or exceed the following thresholds and timetables	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	for primary care practices to achieve NCQA PPC®-PCMH recognition or JCAHO PCH accreditation:			
7.11.3.1	By the end of the first year of operations under the Contract: • Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited.	N/A	DHH has extended the date for achieving the one year goal to June 2013.	
7.11.3.2	By the end of the second year of operation under the Contract: • Total of 30% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited and a • Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited.	Substantial	The targets for accreditation should be included in the PCMH Implementation Plan.	MCO response: The plan will include the targets for accreditation in the PCMH Implementation Plan. IPRO response: Review determination is unchanged. Updated PCMH Implementation Plan will be reviewed to ensure targets are included as part of next year's audit.
7.11.3.3	By the end of the third year of operation under the Contract: Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited, • Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited, and a • Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	Substantial	The targets for accreditation should be included in the PCMH Implementation Plan.	MCO response: The plan will include the targets for accreditation in the PCMH Implementation Plan. IPRO response: Review determination is unchanged. Updated PCMH Implementation Plan will be reviewed to ensure targets are included as part of next year's audit.
7.11.4	The CCN shall submit an annual report indicating PCP practices that	Full	The plan submitted their Annual Recognition/Accreditation Report as evidence.	

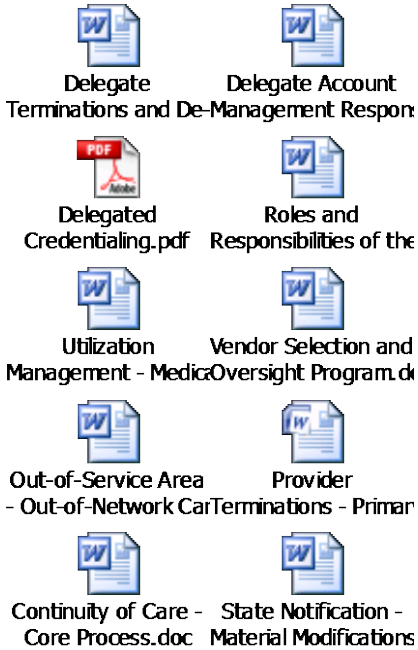
Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	are NCQA PPC®-PCMH recognized, including the levels of recognition, or JCAHO PCH accreditation.			
7.11.5	The CCN shall participate in Patient-Centered Primary Care Collaborative activities.	Full	P.5 of the PCMH Implementation Plan meets this requirement.	
7.11.6	Subsequent renewal of the Contract beyond the initial three year period will require increased percentage of PCP practices to be NCQA recognized or JCAHO accredited to a total of eighty (80%) of practices.	Minimal	This language was not found in the PCMH Implementation Plan.	MCO response: The plan will incorporate language that addresses this in the PCMH Implementation Plan. IPRO response: Review determination is unchanged. Updated PCMH Implementation Plan will be reviewed as part of next year's audit to ensure that percentage of PCP practices accredited meets this standard
7.11.7	The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home Accreditation, and as defined in the terms and conditions of this RFP.	Full	The plan submitted their Annual Recognition/Accreditation Report as evidence. The plan is currently at 8% recognition and the Implementation Plan has been updated for 2013 to describe what the plan will be doing to reach the 1st target of reaching 20% recognition for the 1st year. The plan should continue to update the Implementation Plan on an annual basis to describe barriers faced the previous year, how the plan will address those barriers, and any other activities planned in the coming year to achieve the targets set by the DHH.	
7.12	**Subcontract Requirements**			
7.12.1	The CCN shall provide or assure the provision of all core benefits and services. The CCN may provide these services directly or may enter into subcontracts with providers	Full	The Vendor Selection and Oversight Program P/P meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	who will provide services to the members in exchange for payment by the CCN for services rendered. Provider contracts are required with all providers of services unless otherwise approved by DHH. Any plan to delegate responsibilities of the CCN to a major subcontractor shall be submitted to DHH for approval.			
7.12.2	In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the CCN shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another CCN or in which the CCN represents or agrees that it will not contract with another provider. The CCN shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.	Full	Item 10.2 (Non-exclusivity volume) in the PCP written agreements meets this requirement.	
7.12.3	The CCN shall have written policies and procedures for selection and retention of providers.	Full	The Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	
7.12.3.1	The CCN shall follow the state's credentialing and re-credentialing policy.	Full	The Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	
7.12.3.2	The CCN provider selection policies and procedures must not discriminate against particular	Full	P.22 of the Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	providers that serve high-risk populations or specialize in conditions that require costly treatment.			
7.12.4	All laboratory testing sites providing services under this Contract must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	Full	P.22 of the Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	
7.12.5	The CCN shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:	Full	The Vendor Selection and Oversight Program P/P meets this requirement.	
7.12.5.1	All provider subcontracts must fulfill the requirements that are appropriate to the service or activity delegated under the subcontract.	Full	The plan submitted signed subcontractor agreements, which meet this requirement.	
7.12.5.2	DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	N/A		
7.12.5.3	The CCN must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full	The Vendor Selection and Oversight Program P/P meets this requirement.	
7.12.5.4	The CCN must have a written agreement between the CCN and the subcontractor that specifies the activities and reporting	Full	The plan submitted signed subcontractor agreements as evidence.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.			
7.12.5.5	The CCN shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.	Full	The Vendor Selection and Oversight Program P/P meets this requirement.	
7.12.5.6	The CCN shall identify deficiencies or areas for improvement, and take corrective action.	Full	The Vendor Selection and Oversight Program P/P meets this requirement.	
7.12.5.7	The CCN shall specifically deny payments to subcontractors for Provider Preventable Conditions.	Full	P.4 of the Delegate Terminations and De-delegations P/P meets this requirement. The plan submitted signed subcontractor agreements as evidence.	
7.12.6	The CCN shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Full	P.4 of the Delegate Terminations and De-delegations P/P meets this requirement.	
7.12.7	Notification of amendments or changes to any provider subcontract which materially affects this Contract shall be provided to DHH prior to the execution of the	Full	P.4 of the Delegate Terminations and De-delegations P/P meets this requirement.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	amendment.			
7.12.8	The CCN shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN shall not enter 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.	Full	P. 16 of the Credentialing and Recredentialing for Licensed Independent Practitioners P/P meets this requirement.	
7.12.9	The CCN shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the CCN's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the CCN shall provide immediate written notice to the provider.	Full	Provider/subcontractor contracts (Items 9.2 and 9.3) meet this requirement.	
7.12.10	If termination is related to network access, the CCN shall include in the notification to DHH their plans to notify CCN members of such change	Non-Compliance (Determination changed to	This language was not found in any P/P submitted by the plan including the Provider Terminations - Primary Care Provider, Specialist and Hospital P/P.	MCO response: The Plan disagrees with the review determination. The evidence was submitted in the original submission in the EQRO tool. This evidence can be found under Line

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	and strategy to ensure timely access to CCN members through out-of-network providers. If termination is related to the CCN's operations, the notification shall include the CCN's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.	"Full")		68. The documents are also provided below for easy reference. P&Ps (Line 68) • Delegate Account Management Responsibilities • Delegate Terminations and De-delegations • Delegated Credentialing • Roles and Responsibilities of the Medical Directors and Credentialing Committees • Utilization Management – Medicaid Delegation and Oversight • Vendor Selection and Oversight Program  IPRO response: Based on a re-review of the plan's policies, review

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				determination is changed to "Full." The Delegate Terminations and De-delegations P/P states, "In the event of termination of the contract, communication letters will be sent to affected members and providers as appropriate and in accordance with applicable state required timeframes informing them of the termination and providing instructions on appropriate actions related to the termination and if appropriate, the contingency delegate information. All communications will go through the proper review as required, including Collateral Material Approval Process (CMAP) and state/federal review."
7.12.11	The CCN shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider.	Non-Compliance (Determination changed to "Full")	P.4 of the Delegate Terminations and De-delegations P/P mentions this requirement but for Nevada only.	MCO response: The plan disagrees with the review determination. The evidence was submitted in the original submission in the EQRO tool. This evidence can be found under Line 68 in the EQRO tool. The documents are also provided below for easy reference. <u>P&Ps</u> • Provider Terminations – Primary Care Provider, Specialist and Hospital  Provider Terminations - Primar IPRO response: Based on a re-review of the plan's policy, review determination is changed to "Full." The policy above states "When timely notice of a provider's request to terminate from the network is received from the provider, a notice will be sent to the member within fifteen (15) calendar days of the receipt

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				of the termination notice from the provider."
7.13	**Provider-Member Communication Anti-Gag Clause**			
7.13.1	The CCN 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:	Full	P. 21 of the Provider Handbook meets this requirement.	
7.13.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Full	P. 21 of the Provider Handbook meets this requirement.	
7.13.1.2	Any information the member needs in order to decide among relevant treatment options;	Full	P. 21 of the Provider Handbook meets this requirement.	
7.13.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Full	P. 21 of the Provider Handbook meets this requirement.	
7.13.1.4	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 decisions.	Full	P. 21 of the Provider Handbook meets this requirement.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1	**General Requirements**			
8.1.1	The CCN 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 CCN 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.	Full	Contract requirement met in ANNUAL~1.doc regarding UM denial notices and in CLINIC~1: Department Procedure: Clinical Criteria for Utilization Management Decision_Core_Processes	
8.1.2	The UM Program policies and procedures shall meet all URAC or NCQA standards and include medical management criteria and practice guidelines that: are adopted in consultation with a contracting health care professionals; are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; are consider the needs of the members; are reviewed annually and updated periodically as appropriate.	Full	Addressed in contract language in ANNUAL~1.doc: Department Procedure, Annual Audit of Health Plan Utilization Management Denial Files	
8.1.3	The policies and procedures shall include, but not be limited to:	N/A		
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	Full	Contract requirement met in CLINIC~2 Dept. Procedure: Clinical Information for UM Review – Core Processes	
8.1.3.2	The data sources and clinical review	Full	Addressed in contract language in 2013 LA~1 Provider	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	criteria used in decision making;		Bulletin and in CLINIC~1: Depart. Procedure: Clinical criteria for UM decisions	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Full	Contract requirement met in 2013LA~1 Notice of Action Letter, Provider Bulletin	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Full	Contract requirement met in 2013LA~1.pdf Provider Availability of UM criteria and access to UM staff	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Full	Contract requirement met in CLINIC~1.doc, e.g., use guidelines to "consistently match medical services to patient needs"	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services; and	Full	Contract requirement met in CLINIC~2 Dept Procedure: Clinical Information for UM reviews-Core Process	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information.	Full	Contract requirement met in April_2o13_ProviderHandbook.pdf and Member Handbook May 2013	
8.1.4	The CCN shall coordinate the development of clinical practice guidelines with other DHH CCN's to avoid providers receiving conflicting practice guidelines from different CCN's.	Full	Contract requirement met in 2013 LA~1 Provider Bulletin	
8.1.5	The CCN shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Full	Contract requirement met in 2013 LA~1 Provider Bulletin	
8.1.6	The CCN shall take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers are consistently in compliance, based	Full	Contract requirement met in April 2013 Provider Handbook. Onsite: Plan provided additional documentation, i.e., HEDIS report.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	on CCN measurement findings. The CCN should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.			
8.1.7	The CCN must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	N/A		
8.1.7.1	The vendor must be identified if the criteria was purchased;	Full	Contract requirement met in CLINIC~1-Criteria for UM decision (1-Unicare Medical Policies and Clinical UM Guidelines; 2-Interqual)	
8.1.7.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	Full	Contract requirement met in CLINIC~1;Criteria UM decision-making	
8.1.7.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Full	Contract requirement met in April_2013_ProviderHandbook.pdf	
8.1.7.4	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 CCN medical director or other qualified and trained professionals.	Full	Contract requirement met in: ❑ 2013 LA~1 Provider Bulletin (UM "staffed with clinical professionals") ❑ ASSOC~1 Associates Performing Utilization Review – Core Processes ❑ MEMBER~1.doc-Member Appeals-Core Process	
8.1.8	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions	Full	Contract requirement met in 2013 LA~1 Provider Bulletin regarding dissemination to providers	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.			
8.1.9	The CCN 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 CCN determines the need for additional information not initially requested.	Full	Contract requirement met in: ❑ CLINIC~1 Dept Procedures: Clinical Criteria for UM Decision ❑ CLINIC~2 Dept Procedures: Clinical Information for UM Reviewers	
8.1.10	The CCN 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 CCN may deny authorization of the requested service(s).	Full	Contract requirement met in CLINIC~2 Dept. Procedures: Clinical Information for UM Reviews	
8.1.11	The CCN shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.	Full	Contract requirement met in 2013 LA Provider Bulletin, e.g., “We are staffed with clinical professionals”	
8.1.12	The CCN 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 CCN	Full	Contract requirement met in CLINIC~1 Dept. Procedure: Clinical Criteria UM Decisionmaking	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	shall specify what constitutes "medically necessary services".			
8.1.13	The CCN shall address the extent to which it is responsible for covering services related to the following: the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.	Full	Contract requirement met in May 2013 Member Handbook ENG FINAL.pdf	
8.1.14	The CCN must identify the qualification of staff who will determine medical necessity.	Full	Contract requirement met in ASSOC~1 Associates Performing Utilization Review_ Core Process	
8.1.15	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Full	Contract requirement met in ASSOC~1 Associates Performing Utilization Review_ Core Process	
8.1.16	The CCN 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.	Full	Contract requirement met in ❑ ASSOC~1 Associates Performing Utilization Review_ Core Process ❑ Member~1.doc member Appeals-Core Process ❑ 2013_UM_Program Description_Annotated[1].pdf	
8.1.17	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 hospital, governmental agency or unit, or	Full	Met contractual requirement per documentation provided at on-site visit.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.			
8.1.18	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.	Full	Met contractual requirement per documentation provided at on-site visit (CV; Dept. Procedures: use of Board Certified External medical Consultants	
8.1.19	The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services.	Substantial	Language in 2013_UM_Program_Description_Annotated[1].pdf addresses inappropriate, but not specifically duplicative services	MCO response: The Plan will address duplicate services in the UM 2014 program description and file with the State by March 31, 2014. IPRO response: Review determination is unchanged. Updated UM 2014 will be reviewed as part of next year's audit.
8.1.19.1	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.	Full	Contract requirement met in 2013_UM_Program Description_Annotated[1].pdf	
8.1.19.2	The CCN 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.	Full	Contract requirement met in 2013 LA~1 Provider Bulletin, e.g., UM decision-making based solely on appropriateness of care and service and existence of coverage	
8.1.19.3	The CCN may place appropriate limits on a service on the basis of medical necessity or for the	Substantial	Contract requirement met in CLINIC~1 Dept Procedure: Clinical Criteria for UM Decisionmaking; with EPSDT exception noted in the Out-of-Area/Out-of-Network	MCO response: The plan will clarify that EPSDT exceptions apply to both in area networks as well as out of area networks

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose.		Section of the April 2013 Provider Handbook. Recommendation: Clarify that EPSDT exception applies to both in- area networks, as well as out-of-area networks in provider handbook.	in the Provider Handbook. IPRO response: Review determination is unchanged. Updated Provider Handbook will be reviewed as part of next year's audit.
8.1.20	The CCN 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.	Full	2013 LA~1 Provider Bulletin	
8.1.21	The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit.	Full	April_2013_Provider_Handbook.pdf	
8.1.22	The CCN Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:	N/A		
8.1.22.1	Identification of the enrollee;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.1.22.2	The name of the enrollee's physician;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.1.22.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.1.22.4	The plan of care;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1.22.5	Initial and subsequent continued stay review dates;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.1.22.6	Date of operating room reservation, if applicable;	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.1.22.7	Justification of emergency admission, if applicable.	Full	Contract language in CLINIC~2 Dept Procedure Clinical Information for UM Reviews-Core Process	
8.2	**Utilization Management Committee**			
8.2.1	The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the CCN as appropriate and supports the QAPI Program.	Substantial	Plan Medical Advisory Committee and Plan Quality Management Committee described in 2013_UM_Program Description Annotated[1].pdf; UM Committee not mentioned in UM Program Description, although UM Committee minutes do provide documentation that it does meet to address UM issues and integrate with other functional units per contract requirement. Recommendation: Incorporate designation of a UM Committee into UM Program Description or other specific policy regarding UM Committee.	MCO response: The plan will incorporate the designation of the UM committee into the 2014 UM Program Description or other specific policy regarding the UM committee. IPRO response: Review determination is unchanged. Updated UM 2014 and other relevant policy will be reviewed as part of next year's audit.
8.2.2	The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting. UM Committee responsibilities include:	Full	Documentation provided at on-site review.	
8.2.2.1	Monitoring providers' requests for rendering healthcare services to its members;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.2	Monitoring the medical	Full	Contract requirement met in	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;		2013_UM_Program_Description_Annotated	
8.2.2.3	Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.4	Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.5	Monitoring consistent application of "medical necessity" criteria;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.6	Application of clinical practice guidelines;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.7	Monitoring over- and under-utilization;	Full	Contract requirement met in 2013_UM_Program_Description_Annotated	
8.2.2.8	Review of outliers, and	Full	Documentation provided at on-site review (Policy & Procedure: Over/Under-utilization)	
8.2.2.9	Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.	Full	Contract requirement met in Medical Record Review_LA_2013.doc	
8.2.2.9.1	Medical Record Review Strategy	N/A		
8.2.2.9.1.1	The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided	Full	Contract requirement met in Medical Record Review_LA_2013.doc	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	within thirty (30) days from the date the Contract is signed and annually thereafter. The strategy shall include, at a minimum, the following: designated staff to perform this duty; the method of case selection; the anticipated number of reviews by practice site; the tool the CCN shall use to review each site; and how the CCN shall link the information compiled during the review to other CCN functions (e.g. QI, credentialing, peer review, etc.).			
8.2.2.9.1.2	The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.	Full	Contract requirement met in Medical Record Review_LA_2013.doc	
8.2.3	The CCN shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The CCN shall review each site at least one (1) time during each two (2) year period.	Full	Contract requirement met in Medical Record Review_LA_2013.doc	
8.2.4	The CCN shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances.	Full	Contract requirement met in Medical Record Review_LA_2013.doc	
8.2.5	The CCN shall report the results of	Full	Contract requirement met in Medical Record	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	all medical record reviews to DHH quarterly with an annual summary.		Review_LA_2013.doc	
8.3	**Utilization Management Reports**			
8.3.0	The CCN shall submit utilization management reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the CCN of additional required reports no less than 30 days prior to due date of those reports	Full	Addressed in D0690T~1.pdf UM Medical Record Review Summary Reporting to DHH confirmed at on-site review by review of relevant reports.	
8.4	**Service Authorization**			
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	Full	Contract requirement met in CLINIC~2 Dept. Procedure: Clinical Information for UM Review-Core Process	
8.4.2	The CCN UM Program policies and procedures shall include service authorization policies and procedures for initial and continuing authorization of services that include, but are not limited to, the following:	N/A		
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;	Full	Contract requirement met in CLINIC~2 Dept. Procedure: Clinical Information for UM Review-Core Process	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for	Full	Contract requirement met in CLINIC~1 to use guidelines to "consistently match medical services to patient	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	authorization decisions and consultation with the requesting provider as appropriate;		needs"	
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;	Full	In CLINIC~1: "Only the health plan Medical Director (or appropriate practitioner, e.g., physician, pharmacist, etc) has the authority to deny requested services based on medical necessity." In Govern~1.doc: "A list of board-certified physicians is maintained by each health plan and accessible by the Medical Director for consultation In complex UM cases." Met per on-site review of Dept. procedure for use of Board Certified External Medical Consultants for Medical Necessity Review	
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;	Full	Addressed in May2013 Member Handbook ENG FINAL.pdf	
8.4.2.5	The CCN's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	Full	Met per on-site review of screenshots of automated authorization system, provider & pre-certification process outlier, and early warning report	
8.4.2.6	The CCN's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the CCN regarding the service requests,	Full	Contract language in Member~1.doc: member Appeals Core Process April_2013_ProviderHandbook.pdf indicates there is a "Payment Dispute Tool" on the provider website; Met per on-site review of relevant reports, as well as Dept. Procedure for Clinical Information	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	clinical data to support the decision, and time frames for notification of providers and members of decisions.			
8.5	**Timing of Service Authorization Decisions**			
8.5.1.1	Standard Service Authorization	N/A		
8.5.1.1.1	The CCN shall make eighty 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 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 unless an extension is requested.	Full	Contract language in CLINIC~2 Dept Procedure: Clinical Information for UM Reviews-Core Process	
8.5.1.1.2	An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the CCN justifies to DHH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than (28) calendar days from receipt of the request.	Full	Contract language in CLINIC~2 Dept Procedure: Clinical Information for UM Reviews-Core Process	
8.5.1.1.3	The CCN shall make concurrent review determinations within one (1) business day of obtaining the	Substantial	Contract language in CLINIC~2 Dept Procedure: Clinical Information for UM Reviews-Core Process.	MCO response: File review findings- no additional comments.

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appropriate medical information that may be required.		On-site file review findings: Inpatient: review of 10 files, 3 did not meet timeliness standard, but of these, 2 were only 1 day late. Outpatient: review of 10 files, 4 were 1 day late.	IPRO response: Review determination is unchanged.
8.5.1.2	Expedited Service Authorization	N/A		
8.5.1.2.1	In the event a provider indicates, or the CCN 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 CCN 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.	Full	Language in Dept Procedure documentation provided during on-site review.	
8.5.1.3	Post Authorization The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the CCN justifies to DHH a need for additional information and how the extension is in the member's best interest.	Full	Contract language in CLINIC~2.doc In a communication after the onsite audit was conducted, DHH indicated that this timeframe was misplaced in the contract and that the contract language will be modified.	
8.5.1.3.1	The CCN 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.	Full	Contract language in CLINIC~2.doc	
8.5.1.3.2	The CCN shall not subsequently	Full	Contract language in Dept Procedures: Pre-certification	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	retracts its 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.		of requested services- core process, provided at on-site review	
8.5.1.4	Timing of Notice	N/A		
8.5.1.4.1	Notice of Action	N/A		
8.5.1.4.1.1	Approval [Notice of Action]	N/A		
8.5.1.4.1.1.1	Approval - For service authorization approval for a non-emergency admission, procedure or service, the CCN shall notify the provider 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.	Full	Contract language in CLINIC~2	
8.5.1.4.1.1.2	Approval - For service authorization approval for extended stay or additional services, the CCN shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.	Full	Contract language in CLINIC~2	
8.5.1.4.2	Adverse [Notice of Action]	N/A		

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.5.1.4.2.1	Adverse - The CCN shall notify the member, in writing using language that is easily understood, 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 adverse action.	Substantial	CLINIC~2 addresses advance notice re whether party to be notified by phone, mail, fax; Contract language in Dept. Procedure: Health Care Management Services Denial- Core Process, per provision of documented at on-site review. On-site file review findings: Of the 10 inpatient files reviewed, regarding reason for denial, 6 included a phrase utilizing the term "clinical" in a manner that would not be easily understandable to member, e.g., "clinical was not submitted." Of the 10 outpatient files reviewed, regarding reason for denial, 3 included a phrase utilizing the term "clinical" in a manner that would not be easily understandable to member, e.g., "clinical was not submitted."	MCO response: File review findings- no additional comments. IPRO response: Review determination is unchanged.
8.5.1.4.2.2	Adverse - The CCN 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.	Full	Contract language in CLINIC~2	
8.5.1.5	Informal Reconsideration	N/A		
8.5.1.5.1	As part of the CCN appeal procedures, the CCN should include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Full	Contract requirements met in: **1.** CLINCI~2 re process for requests for practitioner to contact the health plan to request P2P discussion **2.** May_2013 member Handbook ENG FINAL.pdf.	
8.5.1.5.1.1	In a case involving an initial determination or a concurrent review determination, the CCN should provide the member or a provider acting on behalf of the	Full	Contract language in Health~1	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.			
8.5.1.5.1.1.2	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 CCN'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.	Substantial	Contract requirement for P2P Reconsideration in Health~1: Dept Procedure: Health Care Management Services Denial – Core Process. IPRO on-site file review findings: There is a process being conducted and a policy in support of informal reconsideration via peer to peer informal discussion; however, of the 10 files reviewed, 2 were late and 3 were not conducted due to the provider not calling back after contacted by plan with offer to schedule informal reconsideration. Recommendation: Improve process for provider contact for greater facilitation of communication for informal reconsideration	MCO response: File review findings. Policy in place is State approved. Plan will continue to communicate informal reconsideration process to providers. Peer to Peer process to be added to the Provider Handbook. IPRO response: Review determination is unchanged. File review will be conducted next year to evaluate timeliness of responses and communication to the provider as well as other required elements.
8.5.1.5.2	The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	Full	Contract language in May2013 Member handbook ENG FINAL.pdf: "Your provider must ask for a payment appeal within 30 days of receiving the EOB."	
8.5.1.6	Exceptions to Requirements	N/A		
8.5.1.6.1	The CCN 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.	Full	Contract requirement met in May 2013 Member Handbook ENG FINAL.pdf	
8.5.1.6.2	The CCN shall not require hospital service authorization for non-emergency inpatient admissions for	Substantial	On-site review clarification/documentation provided (Dept procedure re concurrent review states that authorization is required for > 48 hours for vaginal	MCO response: File review findings. Plan will communicate process in the member handbook and provider handbook.

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	normal newborn deliveries.		delivery and for > 96 hours for C-section) and 5/11/12 DHH Bulletin re Amerigroup explicitly states that no precertification is required for vaginal and C-section deliveries; however, this latter explicit exception was not found in plan documentation. Recommendation: Explain in member handbook as in DHH memo.	IPRO response: Review determination is unchanged. Updated member and provider handbooks will be reviewed as part of next year's audit. File review will be conducted.
8.5.1.6.3	The CCN shall not require service authorization or referral for EPSDT screening services.	Substantial	Per on-site documentation provided, EPSDT exclusion documented with regard to referral, but not documented with regard to service authorization. EPSDT exception noted in the Out-of-Area/Out-of-Network Section of the April 2013 Provider Handbook. Recommendation: Clarify universal EPSDT exception in member handbook.	MCO response: Plan will clarify universal EPSDT exception in member handbook. IPRO response: Review determination is unchanged. Updated member handbook will be reviewed as part of next year's audit.
8.5.1.6.4	The CCN shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the CCN, regardless of whether such services are provided by an in-network or out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days.	Full	Per documentation provided at on-site review	
8.5.1.6.5	During transition, the CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.	Full	Per documentation provided at on-site review	
8.5.1.6.6	The CCN shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a	Full	Per documentation provided at on-site review (LA MHB 0007-13)	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal care.			
8.5.1.6.7	The CCN shall not require a PCP referral for in-network eye care and vision services.	Full	Contract requirement met per documentation in specialty Referral.doc	
8.5.1.6.8	The CCN may request to be notified by the provider, but shall not deny claims payment based solely on lack of notification, for the following: inpatient emergency admissions within forty-eight (48) hours of admission; obstetrical care (at first visit); and obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	Substantial	UM Program Description states that the plan can only deny the portion of claims beyond the 48th and 96th hour for vaginal and C-section deliveries, respectively; however, in May 2013 Member Handbook this is listed under "Covered services/coverage limits," but the document does not specify that prior service authorization is not needed for payment of claims. In addition, a page of an unknown source document that the plan suggested may be a "provider quick reference" states that "No precertification is required for labor and delivery for newborns up to 12 weeks in age." Plan was unable to explain the meaning of this clause at closing. Recommendation: Clarify in member handbook. In addition, investigate whether the clause in question, above, was included in a provider quick reference tool in error and correct if needed.	MCO response: Plan will clarify in member handbook as well as clarify communication to the provider. IPRO response: Review determination is unchanged. Updated member handbook and provider communication document will be reviewed as part of next year's audit.
8.6	**Medical History Information**			
8.6.1	The CCN 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.	Full	Contract requirement met in CLINIC~2	
8.6.2	The CCN shall take appropriate	Full	Contract requirement met in CLINIC~2	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.			
8.6.3	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.	Full	Contract requirement met in CLINIC~2	
8.6.4	Should a provider fail or refuse to respond to the CCN's request for medical record information, at the CCN's discretion or directive by DHH, the CCN shall, at a minimum, impose financial penalties against the provider as appropriate.	Full	Payment denial per April_2013 Provider Handbook.pdf	
8.7	**PCP Utilization and Quality Profiling**			
8.7.1	The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues.	Full	Contract requirement met in UTILIZ~1.doc, Utilization Management Program Evaluation	
8.7.2	The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Full	Contract requirement met in UTILIZ~1.doc, Utilization Management Program Evaluation	
8.7.3	The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall include, but are not limited to, the following:	Full	AMG PQ072 QAPI PCP Profile 2012 Q4v2.xls; however, this is not individually reported for this QAPI PCP Profile Report; At on-site-review, provider-specific report was provided.	
8.7.3.1	Utilization of out-of-network providers – The CCN shall maintain	Full	AMG PQ072 QAPI PCP Profile 2012 Q4v2.xls	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;			
8.7.3.2	Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	Full	AMG PQ072 QAPI PCP Profile 2012 Q4v2.xls	
8.7.3.3	Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel;	Full	AMG PQ072 QAPI PCP Profile 2012 Q4v2.xls	
8.7.3.4	Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and	Full	AMG PQ072 QAPI PCP Profile 2012 Q4v2.xls	
8.7.3.5	Individual PCP clinical quality performance measures as indicated in Appendix J.	Full	Supporting documentation (reports) provided at on-site review	
8.8	**PCP Utilization & Quality Profile Reporting Requirements**			
8.8.0	The CCN 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 CCN of additional required reports no less than sixty (60) days prior to due date of those reports.	Full	Supporting documentation (reports) provided at on-site review	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.4	**Provider Handbook**			
10.4.1	The CCN shall develop and issue a provider handbook within thirty (30) days of the date the CCN signs the Contract with DHH. The CCN may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the CCN's website. This notification shall also detail how the provider can request a hard copy from the CCN at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding CCN covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all CCN requirements are met. At a minimum, the provider handbook shall include the following information:	Substantial	The Provider Handbook does not mention how providers can obtain a copy of the handbook - either by mail or online. It also does not mention that providers can request a hard copy from the plan at no cost. During the interview, the plan explained that Providers can obtain a copy of the handbook online. They are also issued a hard copy upon joining the network (within 30 days) and issued the latest version in hard copy whenever an onsite visit takes place. The plan also referred to p.41 of the handbook, where this information is contained. P. 41 only refers to the Provider Directory and not the handbook. Information on how to obtain the directory and the handbook should both be in the handbook and mentioned in the beginning of the handbook.	MCO response: The Plan will incorporate this information in both the Provider Directory and the Provider Handbook. IPRO response: Review determination is unchanged. Updated Provider Directory and Provider Handbook will be reviewed as part of next year's audit.
10.4.1.1	Description of the CCN;	Full	P. 7 of the Provider Handbook meets this requirement.	
10.4.1.2	Description and requirements of Patient-Centered Medical Home recognition;	Full	P. 11 of the Provider Handbook meets this requirement.	
10.4.1.3	Core benefits and services the CCN must provide;	Full	P. 23 of the Provider Handbook meets this requirement.	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.4.1.4	Emergency service responsibilities;	Full	P. 61 of the Provider Handbook meets this requirement.	
10.4.1.5	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;	Full	P. 70 of the Provider Handbook meets this requirement.	
10.4.1.6	Information about the CCN's Grievance System, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;	Full	P. 9 and P.38 of the Provider Handbook meet this requirement.	
10.4.1.7	Medical necessity standards as defined by DHH and practice guidelines;	Full	P. 14 of the Provider Handbook meets this requirement.	
10.4.1.8	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Full	P.18 and P.45 meet this requirement.	
10.4.1.9	PCP responsibilities;	Full	P. 12 of the Provider Handbook meets this requirement.	
10.4.1.10	Other provider responsibilities under the subcontract with the CCN;	Full	P. 12 of the Provider Handbook meets this requirement.	
10.4.1.11	Prior authorization and referral procedures;	Full	P. 51 of the Provider Handbook meets this requirement.	
10.4.1.12	Medical records standards;	Full	P.42, P.48 and P.49 meet this requirement.	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.4.1.13	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;	Full	P. 73, P.76 and P.74 of the Provider Handbook meet this requirement.	
10.4.1.14	CCN prompt pay requirements;	Full	P. 76 of the Provider Handbook meets this requirement.	
10.4.1.15	Notice that provider complaints regarding claims payment shall be sent to the CCN;	Full	P. 65 of the Provider Handbook meets this requirement.	
10.4.1.16	The CCN's chronic care management program;	Full	P. 45 of the Provider Handbook meets this requirement.	
10.4.1.17	Quality performance requirements; and	Full	P. 65 of the Provider Handbook meets this requirement.	
10.4.1.18	Provider rights and responsibilities.	Full	P. 12 and P. 21 of the Provider Handbook meet this requirement.	
10.4.2	The CCN shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Full	The plan submitted a Provider Handbook Update document as evidence. This document informs the providers that the handbook has been revised and which sections have been revised. The plan explained that providers are informed of updates to the handbook as needed, usually via fax. If the update is substantial or considered highly important, then the plan will inform the providers on the day that the update is made.	
10.6	**Provider Complaint System**			
10.6.1	The CCN shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the CCN's policies, procedures, or any aspect of the	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCNs administrative functions. As part of the Provider Complaint system, the CCN shall:			
10.6.1.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.1.2	Identify a staff person specifically designated to receive and process provider complaints;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.1.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the CCN's written policies and procedures; and	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.1.4	Ensure that CCN executives with the authority to require corrective action are involved in the provider complaint process as necessary.	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2	The CCN shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The CCN shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed. The policies and procedures shall include, at a minimum:	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.1	Allowing providers thirty (30) days	Full	The Provider Service Inquiry and Complaint System – LA	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to file a written complaint and a description of how providers file complaint with the CCN and the resolution time;		P/P meets this requirement.	
10.6.2.2	A description of how and under what circumstances providers are advised that they may file a complaint with the CCN for issues that are CCN Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the CCN;	Full	The Provider Service Inquiry and Complaint System – LA P/P "states that providers may file complaints directly with DHH regarding issues or concerns that are not unique or specific to Amerigroup Louisiana."	
10.6.2.3	A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.4	A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.5	A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.6	A description of the methods used to ensure that CCN executive staff with the authority to require	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	corrective action are involved in the complaint process, as necessary;			
10.6.2.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.8	Identification of specific individuals who have authority to administer the provider complaint process;	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	Full	The plan submitted copies if their Provider Complaint and Appeal Summary reports and their Disputes Data to show that they have a system which captures, tracks and reports complaints data. **Provider Complaint File Review** A total of 20 provider complaint files were reviewed, all the files were fully compliant. It was noted; however, that 8 out of the 20 complaints/payment disputes were closed because the provider filed the dispute after the 90 day timeframe. The provider complaints staff disclosed that this happens very often, that providers file their disputes late and they do not get paid for legitimate claims. During the interview, it was suggested that for QI purposes, the plan should try to investigate why their network providers are filing disputes late; perhaps it is resource issue (staffing issue at the practice) or lack of education about the plan's grievance procedure.	
10.6.2.10	A provision requiring the CCN to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	Full	The Provider Service Inquiry and Complaint System – LA P/P meets this requirement.	
10.6.2.11	Allowing providers that have exhausted the CCNs internal	Full	P. 72 of the Provider Handbook meets this requirement.	

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	complaint process related to a denied or underpaid claims or a group of claims bundled, the option to request binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the CCN and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the CCN and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.		It is recommended that this contract language is added to the Provider Service Inquiry and Complaint System – LA P/P.	
10.6.3	The CCN shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the CCNs Provider Relations staff; and contact information for the person from the CCN who receives and processes provider complaints.	Full	P. 70 of the Provider Handbook meets this requirement.	
10.6.3.1	The CCN shall distribute the CCN's policies and procedures to in-	Substantial	The plan's P/P relating to complaints is contained in the Provider Handbook.	MCO response: The Plan will incorporate this information in the

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	network providers at time of subcontract and to out-of-network providers with the remittance advice of the pre-processed claim. The CCN may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the CCN's website. This summary shall also detail how the in-network provider can request a hard copy from the CCN at no charge to the provider.		The Provider Handbook does not mention how providers can obtain a copy of the handbook - either by mail or online. It also does not mention that provider can request a hard copy from the plan at no cost.	Provider Handbook. IPRO response: Review determination is unchanged. Updated Provider Handbook will be reviewed as part of next year's audit.
10.6.3.2	The CCN provider shall file all appeals for the denial, reduction or suspension of medically necessary services through the state fair hearing process.	Substantial	P. 34 of the Provider Handbook partially meets this requirement. It is recommended that this contract language is added to relevant P/Ps and the Provider Handbook.	MCO response: The plan will add this contract language to relevant Policy and Procedures and the Provider Handbook. IPRO response: Review determination is unchanged. Updated Policy and Provider Handbook will be reviewed as part of next year's audit.
10.6.3.3	Within fifteen (15) business days of the mailing of the Notice of Adverse Action, the aggrieved provider may request an administrative hearing with the Division of Administrative Law (DAL) by filing a request for administrative hearing with the DAL. After a decision is rendered by the DAL, the aggrieved provider may seek judicial review of the DAL decision within thirty (30) days of the date the final decision is mailed to the parties, pursuant to La. R.S. 49:964. The judicial review petition shall be filed with the 19th Judicial District Court. The District Court's judgment may be appealed, by an	Substantial	P. 34 of the Provider Handbook partially meets this requirement. It is recommended that this contract language is added to relevant P/Ps and the Provider Handbook.	MCO response: The plan will add this contract language to relevant Policy and Procedures and the Provider Handbook. IPRO response: Review determination is unchanged. Updated Policy and Provider Handbook will be reviewed as part of next year's audit.

Provider Relations				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	aggrieved party within the appeal time delays set forth in the Louisiana Code of Civil Procedure.			

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.11	**PCP Auto-Assignments**			
11.11.1	The CCN is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee:	N/A		
11.11.1.1	Does not make a PCP selection after a voluntary selection of a CCN; or	Full	This requirement is addressed in the AGL 7.0 PCP Auto Assignment Methodology and Primary Care Provider Selection, Assignment and Change Requests - LA Policy and Procedure (P&P)	
11.11.1.2	Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or	Full	This requirement is addressed in the AGL 7.0 PCP Auto Assignment Methodology and Primary Care Provider Selection, Assignment and Change Requests - LA P&P	
11.11.1.3	Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).	Full	This requirement is addressed in the AGL 7.0 PCP Auto Assignment Methodology and Primary Care Provider Selection, Assignment and Change Requests - LA P&P	
11.11.2	Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the CCN plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.	Full	This requirement is addressed in the AGL 7.0 PCP Auto Assignment Methodology and Primary Care Provider Selection, Assignment and Change Requests - LA P&P	
11.11.3	If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP	Full	This requirement is addressed in the AGL 7.0 PCP Auto Assignment Methodology and Primary Care Provider Selection, Assignment and Change Requests - LA P&P	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.			
11.11.4	The final CCN and PCP automatic assignment methodology must be provided thirty (30) days from the date the CCN signs the contract with DHH. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the CCN's website, Provider Handbook, and Member Handbook.	Full	Evidence of this requirement is addressed in the Supporting Documents Submitted to DHH report (Within 30 days Deliverables) Evidence of Methodology in Member Handbook and Provider Manual and Website.	
11.11.5	The CCN shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.	Full	Evidence of this requirement is addressed Submission 1st Quarter 2013 Network Adequacy Report – submitted to DHH 4/30/13.	
11.11.6	If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.	Full	As per the Primary Care Provider Selection, Assignment and Change Requests – LA P&P: "Amerigroup will not impose a PCP lock-in program. A member may choose to change his/her PCP at any time and as many times as the member desires. Members are informed of this right and the procedure for how to change their PCP is in the member handbook. The request to change a PCP is processed by the NCC and/or Enrollment Services."	
11.11.7	Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12) months beginning from the original date the member was	Full	As per the Primary Care Provider Selection, Assignment and Change Requests – LA P&P: "Amerigroup will not impose a PCP lock-in program. A member may choose to change his/her PCP at any time and as many times as the member desires. Members are informed of this right and the procedure for how to change their PCP is	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	assigned to the CCN.		in the member handbook. The request to change a PCP is processed by the NCC and/or Enrollment Services."	
11.11.8	If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must agree to grant the request.	Full	As per the Primary Care Provider Selection, Assignment and Change Requests – LA P&P: "Amerigroup will not impose a PCP lock-in program. A member may choose to change his/her PCP at any time and as many times as the member desires. Members are informed of this right and the procedure for how to change their PCP is in the member handbook. The request to change a PCP is processed by the NCC and/or Enrollment Services."	
11.11.9	The CCN shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the CCN, or when a PCP change is ordered as part of the resolution to a grievance proceeding, The CCN shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP.	Full	This requirement is addressed in the AGL 7.0 Auto Assignment Methodology and the following P&Ps: • Primary Care Provider Selection, Assignment and Change Requests - LA • Timely Notification of Participating Provider Termination –LA • Provider Terminations - Primary Care Provider, Specialist and Hospital • Continuity of Care - Core Process	
11.11.11	The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.	Full	This requirement is addressed in the following P&Ps: • Timely Notification of Participating Provider Termination –LA • Provider Terminations - Primary Care Provider, Specialist and Hospital	
11.12	**Disenrollment**			
11.12	Disenrollment is any action taken by	Full	This requirement is addressed in the Disenrollment –	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	DHH or its designee to remove a Medicaid CCN member from the CCN 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 CCN Program. The CCN shall submit to DHH a Quarterly CCN Disenrollment Report which summarizes all disenrollments for its members in the format specified by DHH. The Enrollment Broker shall be the single point of contact to the CCN member for notification of disenrollment.		LA P&P – section Procedures	
11.12.1	Member Initiated Disenrollment	N/A		
11.12.1.1	A member may request disenrollment from a CCN as follows: for cause, at any time. The following circumstances are cause for disenrollment: the member moves out of the CCN's designated service area; the CCN does not, because of moral or religious objections, cover the service the member seeks; the member requests to be assigned to the same CCN as family members; the member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the ember to unnecessary risk; the contract between the CCN and DHH is	Full	This requirement is addressed in the Disenrollment – LA P&P - section Enrollee-Initiated Disenrollment	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	terminated; poor quality of care; lack of access to CCN core benefits and services covered under the contract; documented lack of access within the CCN to providers experienced in dealing with the member's healthcare needs; and any other reason deemed to be valid by DHH and/or its agent.			
11.12.1.2	Without cause for the following reasons: during the 90 day opt-out period following initial enrollment with the CCN for voluntary members; during the 90 days following the postmark date of the member's notification of enrollment with the CCN; once a year thereafter during the member's annual open enrollment period; and upon automatic re-enrollment, if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. If DHH imposes intermediate sanction provisions.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Enrollee-Initiated Disenrollment	
11.12.1.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Enrollee-Initiated Disenrollment	
11.12.1.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Enrollee-Initiated Disenrollment/ Involuntary Disenrollment	
11.12.2	CCN Initiated Disenrollment	N/A		
11.12.2.1	The CCN shall not request	Full	This requirement is addressed in the Disenrollment –	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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 CCN's ability to furnish services to either this particular member or other CCN members, the member attempts to exercise his/her rights under the CCN's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.		LA P&P - section Involuntary Disenrollment	
11.12.2.2	The CCN shall not request disenrollment for reasons other than those stated in this RFP. DHH will ensure that CCN is not requesting disenrollment for other reasons by reviewing 1) the mandatory CCN Disenrollment Request Forms submitted to the Enrollment Broker and 2) Quarterly Disenrollment Reports submitted by the CCN to DHH.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.3	The following are allowable reasons for which the CCN may request involuntary disenrollment of a member: the member misuses or loans the member's CCN-issued ID card to another person to obtain services. In such case the CCN shall report the event to the Medicaid	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Program Integrity Section; the member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members.			
11.12.2.4	The CCN shall take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.5	When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.6	The CCN 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 CCN Initiated Request for Member Disenrollment form.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.7	The CCN shall not submit a	Full	This requirement is addressed in the Disenrollment –	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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 CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.		LA P&P - section Involuntary Disenrollment	
11.12.2.8	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 CCN.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.9	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new CCN. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the CCN, the member has a right to file an appeal directly through the State Fair Hearing process.	N/A	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.2.10	Until the member is disenrolled by the Enrollment Broker, the CCN shall continue to be responsible for the provision of all core benefits and services to the member.	Full	This requirement is addressed in the Disenrollment – LA P&P - section Involuntary Disenrollment	
11.12.3	DHH Initiated Disenrollment: DHH will notify the CCN of the member's disenrollment due to the following	N/A		

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	reasons:			
11.12.3.1	Loss of Medicaid eligibility or loss of CCN enrollment eligibility;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.2	Death of a member;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.3	Member's intentional submission of fraudulent information;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.4	Member becomes an inmate in a public institution;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.5	Member moves out-of-state;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.6	Member becomes Medicare eligible;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.7	Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.8	Member becomes a participant in a home and community-based services waiver;	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.9	Member elects to receive hospice services; and	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	
11.12.3.10	To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law.	Full	This requirement is addressed in the Disenrollment – LA P&P - section DHH Initiated Disenrollment	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.11	**Member Education – Required Materials and Services**			
12.11.0	The CCN shall ensure all materials and services do not discriminate against Medicaid CCN 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 CCN.	Full	This requirement is address in Policy and Procedure (P&P) OBE-11 Non-Discrimination in Marketing, Enrollment and Health Plan Operations. The Americans with Disabilities Act Compliance for Participating Providers P&P also shows compliance for this standard.	
12.11.1.	**New Member Orientation**			
12.11.1.1	The CCN shall have written policies and procedures for the following, but not limited to: orienting new members of its benefits and services; role of the PCP; what to do during the transition period, (e.g. how to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS or CommunityCARE 2.0 to CCN, or from one CCN to another, etc); how to utilize services; what to do in an emergency or urgent medical situation; and how to a file a grievance and appeal.	Full	This requirement is addressed in the following P&P's: Member Education • Member Services Function • Linguistic Services • Cultural Competency The Member Handbook, Provider Manual, Provider Directory and the Member Welcome include Member Orientation information.	
12.11.1.2	The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed	Full	This requirement is addressed in the Member Handbook.	
12.11.1.3	The CCN may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.	Full	This requirement is addressed in the 2013 LA Marketing Plan. The plan states*: "*Amerigroup Louisiana, Inc. has developed this marketing and member education plan incorporating DHH's requirements for participation in the Bayou Health Program. Amerigroup Louisiana, Inc.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			does not engage in marketing and member education activities without receiving prior approval from DHH."	
12.11.1.4	The CCN shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing and include a listing of PCP names (and include locations, and office telephone numbers) that the enrollee may choose as their primary care provider if the file did not contain a PCP selected by the member.	Full	This requirement is addressed in the Member Services Function P&P and the Member Handbook.	
12.11.1.5	The CCN shall submit a copy of the procedures to be used to contact CCN members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed.	N/A	Evidence of this requirement is addressed in the Supporting Documents Submitted to DHH report (Within 30 days Deliverables)	
12.11.1.6	New Medicaid eligibles who have not proactively selected a PCP during the CCN enrollment process or whose choice of PCP is not available will have the opportunity to select a PCP within the CCN that: 1) is a Louisiana Medicaid Program enrolled provider; 2) has entered into a subcontract with the CCN; and 3) is within a reasonable commuting distance from their residence.	Full	This requirement is addressed in the Member Services Function P&P and the Member Handbook.	
12.11.2	**Communication with New Enrollees**			
12.11.2.1.1	The CCN shall send a welcome	Full	This requirement is addressed in the Member Services	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	packet to new members within ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. During the phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to provide welcome packets.		Function P&P and the Member Handbook.	
12.11.2.1.2	The CCN must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the CCN is only required to send one welcome packet.	Full	This requirement is addressed in the Member Services Function P&P.	
12.11.2.1.3	All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:	N/A		
12.11.2.1.3.1	A welcome letter highlighting major program features, details that a card specific to the CCN will be sent via mail separately and contact information for the CCN;	Full	This requirement is addressed in the following P&P's: • Distribution of Member Materials • Member Services Function.	
12.11.2.1.3.2	A Member Handbook;	Full	This requirement is addressed in the following P&P's: • Distribution of Member Materials • Member Services Function	
12.11.2.1.3.3	The CCN Member ID Card; and	Full	This requirement is addressed in the following P&P's: • Distribution of Member Materials	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• Member Services Function	
12.11.2.1.3.4	A Provider Directory (also must be available in searchable format on-line).	Full	This requirement is addressed in the following P&P's: • Distribution of Member Materials • Member Services Function	
12.11.2.3	The CCN shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.	Full	This requirement is addressed in the following P&P's: • Distribution of Member Materials • Member Services Function	
12.11.2.3.1	The CCN shall make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file from DHH or the Enrollment Broker identifying the new enrollee. During the phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to make welcome calls.	Full	This requirement is addressed in the Member Services Function and Linguist Services P&Ps. The PLAN provided the Summary of Analysis for Amerigroup Louisiana - New Member Welcome Calls for Monitoring Marketing Materials for New Members Dated: January – December 2012 Amerigroup established an internal goal of obtaining a 70% "Yes or No" response rate for each of the six questions in the survey which assess a member's level of understanding. These questions were asked during the new member welcome call. The total number of members reached is 20,446. Four of the six questions met the internal goal.	
12.11.2.3.2	The CCN shall develop and submit to DHH for approval a script to be used during the welcome call to discuss the following information with the member:	N/A	This requirement is addressed in Summary of Analysis for Amerigroup Louisiana - New Member Welcome Calls for Monitoring Marketing Materials for New Members Dated: January – December 2012 Recommend to add this requirement to the Member Services Function P&P.	
12.11.2.3.2.1	A brief explanation of the program;	Full	This requirement is addressed in Member Services Function P&P.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.11.2.3.2.2	Statement of confidentiality;	Full	This requirement is addressed in Member Services Function P&P.	
12.11.2.3.2.3	The availability of oral interpretation and written translation services and how to obtain them free of charge;	Full	This requirement is addressed in Member Services Function P&P.	
12.11.2.3.2.4	The concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and	Full	This requirement is addressed in Member Services Function P&P.	
12.11.2.3.2.5	A discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.	Full	This requirement is addressed in Member Services Function P&P.	
12.11.2.3.3	The CCN shall make three (3) attempts to contact the member. If the CCN discovers that the member lost or never received the welcome packet, the CCN shall resend the packet.	Full	This requirement is addressed in Member Services Function P&P.	
12.11.2.3.4	The CCN shall report to DHH on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact.	Full	This requirement is addressed in Member Services Function P&P.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.12	**CCN Member Handbook**			
12.12.1	The CCN shall develop and maintain a member handbook.	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2	Member handbook shall include the following information:	N/A		
12.12.2.1	Table of contents;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.2	A general description about how CCNs operate, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.3	Member's right to disenroll from CCN;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.4	Member's right to change providers within the CCN;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.5	Any restrictions on the member's freedom of choice among CCN providers;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.6	Member's rights and protections;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.7	The amount, duration, and scope of benefits available to the member under the contract between the CCN and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs, including chronic care management;	Full	This requirement is addressed in the 2013 Member Handbook.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Contract Requirement Language	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	MCO Response and Plan of Action
12.12.2.8	Procedures for obtaining benefits, including prior authorization requirements;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.9	Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.10	The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.11	The extent to which, and how, after-hours and emergency coverage are provided, including:	N/A		
12.12.2.11.1	What constitutes an emergency medical condition, emergency services, and post-stabilization services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.11.2	That prior authorization is not required for emergency services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.11.3	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.11.4	The mechanism, incorporated in the member grievance procedures, by which a member may submit, whether oral or in writing, a service authorization request for the provision of services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.11.5	The locations of any emergency settings and other locations at	Full	This requirement is addressed in the 2013 Member Handbook.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	which providers and hospitals furnish emergency services and post-stabilization services covered by the CCN; and			
12.12.2.11.6	That the member has a right to use any hospital or other setting for emergency care.	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.12	The post-stabilization care services rules;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.13	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.14	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the CCN's contract with DHH, including pharmacy cost sharing for certain adults;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.15	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 CCN if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.16	For counseling or referral services that the CCN does not cover because of moral or religious objections, the CCN is required to furnish information on how or where to obtain the service;	Full	This requirement is addressed in the 2013 Member Handbook.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Contract Requirement Language	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	MCO Response and Plan of Action
12.12.2.17	Member grievance, appeal and state fair hearing procedures and time frames;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18	Grievance, appeal and fair hearing procedures that include the following:	N/A		
12.12.2.18.1	For State Fair Hearing: The right to a hearing;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.2	The method for obtaining a hearing; and	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.3	The rules that govern representation at the hearing.	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.4	The right to file grievances and appeals;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.5	The requirements and timeframes for filing a grievance or appeal;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.6	The availability of assistance in the filing process;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.7	The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.8	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	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.9	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.	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.18.10	In a State Fair Hearing, the Division	Full	This requirement is addressed in the 2013 Member	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.		Handbook.	
12.12.2.19	Advance Directives. A description of advance directives which shall include:	N/A		
12.12.2.19.1	The CCN policies related to advance directives;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.19.2	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;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.19.3	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	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.19.4	Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.20	Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family	Full	This requirement is addressed in the 2013 Member Handbook.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	size, living arrangements, parish of residence, or mailing address changes;			
12.12.2.21	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.22	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.23	How to obtain emergency and non-emergency medical transportation;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.24	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.25	Information about the requirement that a member shall notify the CCN 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;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.26	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the CCN;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.27	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or	Full	This requirement is addressed in the 2013 Member Handbook.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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;			
12.12.2.28	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, Spanish and Vietnamese;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.29	Information on the member's right to a second opinion at no cost and how to obtain it;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.30	Any additional text provided to the CCN by DHH or deemed essential by the CCN;	N/A		
12.12.2.31	The date of the last revision;	Full	This requirement is addressed in the 2013 Member Handbook.	
12.12.2.32	Additional information that is available upon request, including the following: information on the structure and operation of the CCN; physician incentive plans; service utilization policies; and how to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.	Full	This requirement is addressed in the Developing and Revising Member Handbooks P&P.	
12.13	**Member Identification (ID) Card**			
12.13.1	CCN members will receive two (2) member identification cards.	Full	This requirement is addressed Member ID Card – LA P&P and the Member Handbook	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.13.1.1	A DHH issued ID card to all Medicaid eligibles, including CCN members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by CCN providers. These systems will contain the most current information available to DHH, including specific information regarding CCN enrollment. There will be no CCN specific information printed on the card. The CCN member will need to show this card to access Medicaid services not included in the CCN core benefits and services.	Full	This requirement is addressed Member ID Card – LA P&P and the Member Handbook	
12.13.1.2	A CCN issued member ID card that contains information specific to the CCN. The members ID card shall at a minimum include, but not be limited to the following: The member's name and date of birth; The CCN's name and address; Instructions for emergencies; The PCP's name, address and telephone numbers (including after-hours number, if different from business hours number); and The toll-free number(s) for: 24-hour Member Services and Filing Grievances, Provider Services and Prior Authorization and Reporting Medicaid Fraud (1-800-488-2917).	Full	This requirement is addressed Member ID Card – LA P&P and the Member Handbook	
12.13.2	The CCN shall issue the CCN Member ID card with the welcome packet. As part of the card mailing, the CCN must explain the purpose	Full	This requirement is addressed the following P&Ps: Member ID Card – LA Member Service Functions	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of the card, how to use the card, and how to use it in tandem with the DHH-issued card.		The Member Welcome letter also shows compliance with this standard.	
12.13.3	The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.	Full	This requirement is addressed Member ID Card – LA P&P.	
12.13.4	Once PCP selection has been made by the member or through auto assignment, the CCN will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the CCN must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous card.	Full	This requirement is addressed Member ID Card – LA P&P and the Member Handbook.	
12.13.5	The CCN shall reissue the CCN ID card within ten (10) calendar days of notice that a member reports a lost card, there is a member name change or the PCP changes, or for any other reason that results in a change to the information on the member ID card.	Full	This requirement is addressed Member ID Card – LA P&P.	
12.13.6	The holder of the member identification card issued by the CCN shall be a CCN member or guardian of a member. If the CCN has knowledge of any CCN member permitting the use of this identification card by any other person, the CCN shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-	Full	This requirement is addressed the following P&Ps: Member ID Card – LA Member Service Functions The Member Welcome letter also shows compliance for this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	2917.			
12.13.7	The CCN shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all core benefits and services and/or expanded services and out of network services.	Full	This requirement is addressed the following P&Ps: Member ID Card – LA	
12.14	**Provider Directory for Members**			
12.14.1	The CCN shall develop and maintain a Provider Directory in four (4) formats:	N/A		
12.14.1.1	A hard copy directory for members and upon request, potential members;	Substantial (Based upon a re-review of the member Services Functions Policy, determination is changed to "Full")	This requirement is addressed P&P Provider Directories and Referral Directories. The P&P states: *The hardcopy directory must be reprinted with updates annually at a minimum.* Recommendation to include: A hard copy directory will be available upon request for members and potential members.	MCO response: Plan disagrees with this review determination. Plan submitted this information in the original documentation to EQRO. Please see below the location on the documents that were submitted to address this part of the contract. We have also embedded this documentation into this tool for your reference. P&Ps (Refer to Line 26 of Crosswalk) • Member Services Functions  Member Services Functions (2).docx IPRO response: Based on a re-review of Member Services Functions Policy, which contains language that members may receive directories upon request, the determination is changed from substantial to "Full." It is recommended that the policy be explicitly expanded to prospective members as well.

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.14.1.2	Web-based, searchable, online directory for members and the public; and	Substantial (Based on a review of the online provider directory, determination changed to "Full")	Amerigroup advised that the Web-based, searchable, online directory for members and the public was still in development. Screen shots of the web-based directory were presented during the onsite.	MCO response: The plan disagrees with this review determination. The evidence was supplied in the original submission. The directory is available to members online and the directory is searchable. Member website – provider directory  Provider Directories and Referral Director  May_2013_Provider_ Directory.pdf  Find a Provider (screenshot # 1).pdf  Find a Provider (screenshot # 2).pdf IPRO response: Based on a review of the online provider directory, which was accessible by members during the review period, the determination is changed from "Substantial" to "Full."
12.14.1.3	Electronic file of the directory for the Enrollment Broker.	Substantial	The plan advised that this is not required as the template was "provided by State to us versus us to State." Recommendation that the plan should document that the enrollment broker received an electronic file of the directory.	MCO response: The plan disagrees with this assessment. File 834 –Enrollment file is a file that is sent to the plan From Maximus (Enrollment Broker). The plan processes the file on a daily basis.  LA EB 834 005010X220A1 Comp IPRO response: Review determination is unchanged. The requirement is that the plan should document that the enrollment broker received an electronic version of the plan's provider directory.
12.14.1.4	Hard copy, abbreviated version for	Full	This requirement is addressed Provider Directories and	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the Enrollment Broker.		Referral Directories P&P.	
12.14.2	DHH or its designee shall provide the file layout for the electronic directory to the CCN after approval of the Contract. The CCN shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed.	N/A		
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 for new members and to fulfill requests by potential members. The web-based online version shall be updated in real time, however no less than weekly. The electronic version shall be updated prior to each submission to DHH's Fiscal Intermediary. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to new Medicaid enrollees. Format for this version will be in a format specified by DHH.	Full	This requirement is addressed Provider Directories and Referral Directories P&P.	
12.14.4	The provider directory shall include, but not be limited to:	N/A		
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,	Full	The requirements were addressed in the May 2013 Provider Directory provided during the onsite. Recommendation to include the requirements in the Provider Directories and Referral Directories P&P.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	PCPs, specialists, and hospitals at a minimum, that are not accepting new patients;			
12.14.4.2	Identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area;	Full	The requirements were addressed in the May 2013 Provider Directory provided during the onsite. Recommendation to include the requirements in the Provider Directories and Referral Directories P&P.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Full	The requirements were addressed in the May 2013 Provider Directory provided during the onsite. Recommendation to include the requirements in the Provider Directories and Referral Directories P&P.	
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).	Full	The requirements were addressed in the May 2013 Provider Directory provided during the onsite. Recommendation to include the requirements in the Provider Directories and Referral Directories P&P.	
12.15	**Member Call Center**			
12.15.1	The CCN shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.1	Explanation of CCN policies and procedures;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.2	Prior authorizations;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• NCC Provider Services Functions	
12.15.1.3	Access information;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.4	Information on PCPs or specialists;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.5	Referrals to participating specialists;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.6	Resolution of service and/or medical delivery problems; and	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.1.7	Member grievances.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.2	The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding state declared holidays.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.3	The toll-free line shall have an automated system, available 24-hours a day, seven days a week.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The CCN must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.		• Member Services s Functions • NCC Provider Services Functions	
12.15.4	The CCN shall have sufficient telephone lines to answer incoming calls. The CCN shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Member Services s Functions • NCC Provider Services Functions	
12.15.5	The CCN must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for CCN performance. The CCN must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may	Full	The requirements were addressed in the Medical Services Staffing - Clinical Associates - Call Centers P&P	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.			
12.15.6	The CCN must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The CCN shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The CCN call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Customer Inquiry Logs • Member Services Functions • NCC Provider Service Functions • Telephonic Access Guidelines During the onsite, the plan provided the Member Call Center Report for Jan – July 2013. The PLAN averaged 99.6% for calls answered within 30 seconds. This surpassed the LA State Requirement of 90% by 9.6%.	
12.15.7	The CCN shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The CCN shall submit call center quality criteria and protocols to DHH for review and approval annually.	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Customer Inquiry Logs • Member Services Functions • NCC Provider Service Functions • Telephonic Access Guidelines	
12.16	**ACD System**			

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.16.1	The CCN shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:	N/A		
12.16.1.1	Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Customer Inquiry Logs • Member Services Functions • NCC Provider Service Functions • Telephonic Access Guidelines	
12.16.1.2	Transfer calls to other telephone lines;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Customer Inquiry Logs • Member Services Functions • NCC Provider Service Functions • Telephonic Access Guidelines	
12.16.1.2.1	Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;	Full	The requirements were addressed in the following P&Ps: • Call Monitoring • Customer Inquiry Logs • Member Services Functions • NCC Provider Service Functions • Telephonic Access Guidelines During the onsite, the plan provided the Member Call Center Report for Jan – July 2013. The plan averaged 99.6% for calls answered within 30 seconds. This surpassed the LA State Requirement of 90% by 9.6%.	
12.16.1.3	Provide a message that notifies callers that the call may be monitored for quality control purposes;	Full	The requirement is addressed in the Telephonic and Voicemail Services P&P.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.16.1.4	Measure the number of calls in the queue at peak times;	Full	The requirement is addressed in the Telephonic and Voicemail Services P&P.	
12.16.1.5	Measure the length of time callers are on hold;	Full	The requirement is addressed in the Member Service Call Tracking Report	
12.16.1.5.1	Measure the total number of calls and average calls handled per day/week/month;	Full	The requirement is addressed in the Member Service Call Tracking Report	
12.16.1.6	Measure the average hours of use per day;	Full	The requirement is addressed in the Member Service Call Tracking Report	
12.16.1.7	Assess the busiest times and days by number of calls;	Full	The requirement is addressed in the Member Service Call Tracking Report	
12.16.1.8	Record calls to assess whether answered accurately;	Full	The requirement is addressed in the Call Monitoring P&P	
12.16.1.8.1	Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;	Full	The requirement is addressed in the Business Continuity Plan.	
12.16.1.8.2	Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and	Substantial	The requirement is addressed in the Telephonic and Voicemail Service P&P. The decision tree illustrating IVR system was not submitted for review.	MCO response: The following document addresses review determination concerns.  Voice Portal Communication (Final IPRO response: Review determination is unchanged. Documentation submitted is dated after the review period of this audit. Documentation will be reviewed as part of next year's audit.
12.16.1.9	Inform the member to dial 911 if there is an emergency.	Full	The requirement is addressed in the Telephonic and Voicemail Service P&P.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.16.2	Call Center Performance Standards	Full	The requirement is addressed in the Telephonic Access Guidelines P&P.	
12.16.2.1	Answer ninety (90) percent of calls within thirty (30) seconds or an automatic call pickup system;	Full	The requirement is addressed in the Telephonic Access Guidelines P&P.	
12.16.2.2	No more than one percent (1%) of incoming calls receive a busy signal;	Full	The requirement is addressed in the Telephonic Access Guidelines P&P.	
12.16.2.3	Maintain an average hold time of three (3) minutes or less;	Full	The requirement is addressed in the Telephonic Access Guidelines P&P.	
12.16.2.4	Maintain abandoned rate of calls of not more than five (5) percent.	Full	The requirement is addressed in the Telephonic Access Guidelines P&P.	
12.16.2.4.1	The CCN must conduct ongoing quality assurance to ensure these standards are met.	Full	The requirement is addressed in the Telephonic Access Guidelines P&P. During the onsite, the plan provided the Member Call Center Report for Jan – July 2013. The plan averaged 99.6% for calls answered within 30 seconds. This surpassed the LA State Requirement of 90% by 9.6%.	
12.16.2.4.2	If DHH determines that it is necessary to conduct onsite monitoring of the CCN's member call center functions, the CCN is responsible for all reasonable costs incurred by DHH or its authorized agent(s) relating to such monitoring.	Substantial	Amerigroup acknowledged this requirement. Recommendation was made to include this requirement in the Call Monitoring P&P.	MCO response: The plan will include this documentation in the Policy and Procedure as recommended. IPRO response: Review determination is unchanged. Updated policy will be reviewed as part of next year's audit.
12.16.2.5	The CCN shall have written policies regarding member rights and responsibilities. The CCN shall comply with all applicable state and federal laws pertaining to member rights and privacy. The CCN shall further ensure that the CCN's employees, contractors and CCN	Full	The requirement is addressed in the Member Rights and Responsibilities – LA P&P Amerigroup submitted the Guidelines for Working with Members training manual as evidence for this requirement. The Member Handbook and Provider Manual also show	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	providers consider and respect those rights when providing services to members.		compliance with this standard.	
12.16.3	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard. The Member's Rights and Responsibilities were also featured in the following news bulletins: • 2013 LA NCQA Provider Bulletin Annotated • 2012 Quality News Supplement (to members)	
12.16.4	**Member Responsibilities**			
12.16.4.1	The CCN 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.	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2	The CCN members' responsibilities shall include but are not limited to:	N/A		
12.16.4.2.1	Informing the CCN of the loss or theft of their ID card;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.2	Presenting their CCN ID card when using health care services;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.3	Being familiar with the CCN procedures to the best of the member's abilities;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.4	Calling or contacting the CCN to obtain information and have questions answered;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.5	Providing participating network providers with accurate and complete medical information;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.6	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	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	followed, as soon as possible;			
12.16.4.2.7	Living healthy lifestyles and avoiding behaviors know to be detrimental to their health;	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.8	Following the grievance process established by the CCN if they have a disagreement with a provider; and	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.16.4.2.9	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.	Full	The requirement is addressed in the following P&Ps: • Member Rights and Responsibilities – LA • Member Services Functions The Member Handbook and Provider Manual also show compliance with this standard.	
12.17	**Notice to Members of Provider Termination**			
12.17.1	The CCN 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 is 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	Full	The requirement is addressed in the Provider Terminations - Primary Care Provider, Specialist and Hospital P&P.	
12.17.2	The CCN shall provide notice to a member, who has been receiving a	Full	The requirement is addressed in the following P&Ps: • Provider Terminations - Primary Care	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.		Provider, Specialist and Hospital • Continuity of Care - Core Process	
12.17.3	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 CCN, 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 CCN becoming aware of the circumstances.	Full	The requirement is addressed in Continuity of Care - Core Process P&P.	
121.8	**Additional Member Educational Materials and Programs**			
12.8.0	The CCN shall prepare and distribute educational materials, including, but not limited to, the following:	N/A		
12.18.1	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;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.2	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.3	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.4	Materials focused on health promotion programs available to the members;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.5	Communications detailing how members can take personal responsibility for their health and self management;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Featured on the Website: Health A-Z Member Handbook	
12.18.6	Materials that promote the availability of health education classes for members;	Full	Addressed in 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA	
12.18.7	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Full	Addressed in Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding • LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.8	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;	Full	Distribution of Member Materials – LA P&P 2013 Louisiana Marketing Plan Community Events, Educational Events, Health Fairs and Plan Presentations – LA The following examples of bulletins and/or newsletters were presented on site as evidence for addressing this requirement: • 2012 Quality News Supplement • LA A Tips Type 2 Diabetes • LA A Tips Breastfeeding	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			• LA A Tips Children and Lead Poisoning • Tobacco Use – Break the Habit/Reasons to Quit Featured on the Website: Health A-Z	
12.18.9	Notification to its members their right to request and obtain the welcome packet at least once a year;	Substantial	The Plan acknowledges that this requirement is provided to their members. However, it is not addressed in the Distribution of Member Materials P&Ps or the Member Handbook Recommend to include in the P&P and Member Handbook The Plan may want to give consideration to include this information as part of an upcoming Member Newsletter.	MCO response: The Plan will include this information as a part of an upcoming Member Newsletter. IPRO response: Review determination is unchanged. Newsletter will be reviewed as part of next year's audit.
12.18.10	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	Full	The requirement is addressed in the 12.2. Marketing and Member Education Plan section of the 2013 Louisiana Marketing Plan.	
12.18.11	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	Full	The requirement is addressed in the 12.1. General Guidelines section of the 2013 Louisiana Marketing Plan.	
12.19	**Oral and Written Interpretation Services**			
12.19.1	The CCN must make real-time oral 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 and Vietnamese). The enrollee is not to be charged for interpretation services. The CCN must notify its enrollees that oral interpretation is available for any	Full	The requirement is addressed in the Linguistic Services P&P and the 2013 Louisiana Marketing Plan. The Voiance Call Detail Report is provided by the language service provider for review along with the Voiance Contract.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.			
12.19.2	The CCN shall ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of a CCN within the GSA. Within 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 CCN and use services appropriately.	Full	The requirement is addressed in the Linguistic Services P&P and the 2013 Louisiana Marketing Plan.	
12.20	**Marketing Reporting and Monitoring**			
12.20.1	Reporting to DHH	N/A		
12.20.1.1	The CCN must provide a monthly report in a format prescribed by DHH (See Appendix BB, Marketing Plan Monthly Report) to demonstrate the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.	Full	The requirement is addressed in 12.20 Marketing Reporting and Monitoring section of the 2013 Louisiana Marketing Plan. Amerigroup provided a sample of the monthly report submitted to DHH: Sample Monthly Report of Marketing and Member Education This report featured the date and time of the event, description, address and host of the event, along with the Parish and the targeted audience (general community).	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.20.1.2	A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year.	Full	The requirement is addressed in 12.20 Marketing Reporting and Monitoring section of the 2013 Louisiana Marketing Plan.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
13.0	**Member Grievance and Appeals Procedures**			
13.0.1	The CCN must have a grievance system. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.	Full	System and procedures documented in Member Handbook (May 2013_Member Handbook ENG_Final.pdf) And as depicted in Process Flow Member Compliants.pdf	
13.0.2	The CCN's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.	Full	Documentation provided at on-site review (email from DHH and Policy for member appeals)	
13.0.3	The CCN shall refer all CCN members who are dissatisfied with the CCN or its subcontractor in any respect to the CCN's designee authorized to review and respond to grievances and appeals and require corrective action.	Full	Process explained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.0.4	The member must exhaust the CCN's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.0.5	The CCN shall not create barriers to timely due process. The CCN shall be subject to sanctions if it is determined by DHH that the CCN has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions	Substantial	Per reports provided at on-site review, 0% was appealed to the State Fair Hearing within a 12 month period. In addition, the plan did not fail to inform the member about continuation of benefits and did not fail to log and process grievances and appeals. Of 20 grievance files reviewed, all but 2 met all	MCO response: File review findings AGP has had 9 appeals that have gone to State Fair Hearing for Medical Necessity since February 2012. 0% of these were reversed or resolved in the member's favor, all were UPHELD.

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to: including binding arbitration clauses in CCN member choice forms; labeling complaints as inquiries and funneled into an informal review; failing to inform members of their due process rights; failing to log and process grievances and appeals; failure to issue a proper notice including vague or illegible notices; failure to inform of continuation of benefits; and failure to inform of right to State Fair Hearing.		applicable requirements; these 2 did not show full investigation of the issue, as the plan was unable to contact the member, but did not attempt to contact the provider about the issue noted by the member (the plan agreed with these findings).	The 20 grievance files were not applicable to State Fair Hearing as they were never appealed for Medical Necessity, they were grievances. The process for grievances is to appeal and then to State Fair Hearing, if appropriate. The 2 files did not show full investigation and we agree on the findings just not sure this is applicable to this requirement. IPRO response: Review determination is unchanged. Auditor agrees that the failure to fully investigate is not specifically noted in the standard but failure to do so is a barrier impairing due process, which does not meet this contract requirement.
13.1	**Applicable Definition**			
13.1.1	Definition of Action - An action is defined as: the denial or limited authorization of a requested service, including the type or level of service; or the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner; or the failure of the CCN to act within the timeframes provided.	Full	Contract language contained in Member Appeals-Core Process.doc	
13.1.2	Definition of Appeal - An appeal is defined as a request for review of	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	an action.			
13.1.3	Definition of Grievance - A grievance is defined as an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes grievances and appeals handled at the CCN level.	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.2	**General Grievance System Requirement**			
13.2.1	Grievance System. The CCN 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 CCN's appeal process has been exhausted.	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.2.2	Filing Requirements	N/A		
13.2.2.1	Authority to File	N/A		
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and a CCN level appeal, and may request a State Fair Hearing, once the CCN's appeals	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	process has been exhausted.			
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.	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.2.3	Time Limits for Filing. The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	Full	Contract language contained in Member Appeals- Core Process.doc	
13.2.4	Procedures for Filing. The member may file a grievance either orally or in writing with the CCN. The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.	Full	Contract language contained in Member Handbook (May 2013_Member Handbook ENG_Final.pdf) Contract language contained in Member Appeals- Core Process.doc	
13.3	**Notice of Grievance and Appeal Procedures**			
13.3.1	The CCN shall ensure that all CCN members are informed of the State	Full	Contract Requirement met per language in Member Handbook (May 2013_Member Handbook	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Fair Hearing process and of the CCN's grievance and appeal procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the CCN shall be available through the CCN, and must be provided upon request of the member. The CCN shall make all forms easily available on the CCN's website.		ENG_Final.pdf) Documents provided at on-site review support that forms are available to the members (copies of forms provided to reviewer). It was also evident from file reviews that these contract requirements were met.	
13.4	**Grievance/Appeal Records and Report**			
13.4.1	The CCN must maintain records of all grievances and appeals. A copy of grievances 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.	Full	Contract language in Member Grievances Resolution_LA_tc docx_compliance edits.docx: Dept. Procedure: Member Grievance Resolution-LA	
13.4.2	The CCN shall electronically provide DHH with a monthly report of the grievances/appeals in accordance	Full	Reports supporting requirement: ✓ AMGPI 182 Provider Compliant & Appeal Summary 2012 07.pdf provides summary	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.		data ✓ Disputes Data_Feb 2012-Dec 2012.xls – ✓ DHH redacted reports provided at on-site review	
13.4.3	The CCN will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the CCN member. DHH may submit recommendations to the CCN regarding the merits or suggested resolution of any grievance/appeal.	Full	Documentation provided at on-site review (Bayou Health Grievance and Appeals Report)	
13.5	**Handling of Grievances and Appeal**			
13.5.1	General Requirements - In handling grievances and appeals, the CCN must meet the following requirements:	N/A		
13.5.1.1	Acknowledge receipt of each grievance and appeal in writing;	Full	IPRO on-site file review findings: 20/20 met this requirement	
13.5.1.2	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	Full	Contract requirement met in May 2013_Member Handbook ENG FINAL.pdf	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	capability;			
13.5.1.3	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.	Full	Contract requirements met in ✓ May 2013_Member Handbook ENG FINAL.pdf ✓ CLINIC~1: Dept Proc: Clinical criteria for UM Decisionmaking ✓ Assoc~1: Associates performing UR ✓ May 2013_Member Handbook ENG FINAL.pdf	
13.5.2	Special Requirements for Appeals The process for appeals must:	N/A		
13.5.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests 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 enrollee follow-up is required.	Full	Contract Requirement met per language in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.5.2.2	Provide the member a reasonable	Full	Contract Requirement met per language in Member	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The CCN must inform the member of the limited time available for this in the case of expedited resolution).		Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.5.2.3	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.	Full	Contract Requirement met per language in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.5.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	Full	Contract Requirement met per language in Member Handbook (May 2013_Member Handbook ENG_Final.pdf)	
13.5.3	Training of CCN Staff - The CCN's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	Full	Contract requirements met in Member%20Compliants%20and%20Grievances[1].pdf: Corporate Policy: Member complaints and grievances	
13.5.4	Identification of Appropriate Party - The appropriate individual or body within the CCN having decision making authority as part of the grievance/appeal procedure shall be identified.	Full	Contract requirements met in Member Appeals-Core Processes.doc	
13.5.5	Failure to Make a Timely Decision - Appeals shall be resolved no later than stated time frames and all parties shall be informed of the	Substantial	Contract requirements met in Member Appeals-Core Processes.doc IPRO on-site file review findings: 17/20 met timeliness standard	MCO response: File review findings IPRO response:

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN's decision. If a determination is not made in accordance with the timeframes specified in 13.7, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.			Review determination is unchanged.
13.5.6	Right to State Fair Hearing - The CCN shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the CCN's decision in response to an appeal and the process for doing so.	Substantial	Contract requirements met in Member Appeals-Core Processes.doc IPRO on-site file review findings: 19/20 with 1 file lacking documentation that the member was informed about the state fair hearing, continuation of benefits, and that for denials upheld the member might incur liability for costs.	MCO response: File review findings IPRO response: Review determination is unchanged.
13.6	**Notice of Action**			
13.6.1	Language and Format Requirements - The notice must be in writing and must meet the language and format requirements to ensure ease of understanding.	Substantial.	IPRO on-site file inpatient review findings: Notice of action contained required content per 13.6.2, below; however, regarding reason for denial, 6 included a phrase utilizing the term "clinical" in a manner that would not be easily understandable to member, e.g., "clinical was not submitted." IPRO on-site outpatient file review findings: Notice of action contained required content per 13.6.2, below; however, regarding reason for denial, 3 included a phrase utilizing the term "clinical" in a manner that would not be easily understandable to member, e.g., "clinical was not submitted."	MCO response: File review findings IPRO response: Review determination is unchanged.
13.6.2	Content of Notice of Action - The Notice of Action must explain the following:	N/A	Contract requirement met in sample letter: DENIAL~1.doc	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
13.6.2.1	The action the CCN or its contractor has taken or intends to take;	Full	Contract requirement met in sample letter: DENIAL~1.doc	
13.6.2.2	The reasons for the action;	Full	Field for "Specific Reason for Admit Denial" in DENIAL~1	
13.6.2.3	The member's or the provider's right to file an appeal with the CCN;	Full	Contract requirement met in sample letter: DENIAL~1.doc	
13.6.2.4	The member's right to request a State Fair Hearing, after the CCN's appeal process has been exhausted;	Full	Language in May 2013 Member Handbook	
13.6.2.5	The procedures for exercising the rights specified in this section;	Full	May 2013 Member Handbook	
13.6.2.6	The circumstances under which expedited resolution is available and how to request it; and	Full	May 2013 Member Handbook	
13.6.2.7	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.	Full	May 2013 Member Handbook; also in Member Appeals-Core Processes document	
13.6.3	Timing of Notice of Action The CCN must mail the Notice of Action within the following timeframes:	N/A		
13.6.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action.	Full	Addressed in April 2013 Provider Handbook	
13.6.3.2	For denial of payment, at the time	Substantial	Review determination was based upon findings from	MCO response:

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of any action affecting the claim.		IPRO file review of denial notices with regard to timeliness standard.	File review findings IPRO response: Review determination is unchanged.
13.6.3.3	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 CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Substantial	Contract language in CLINIC-2: Dept. Procedure-Clinical Information for UM Review- Core Processes IPRO inpatient file review findings: 3 of 10 did not meet timeliness standard, but of these, 2 were only 1 day late. IPRO outpatient file review findings: 4 of 10 were 1 day late	MCO response: File review findings IPRO response: Review determination is unchanged.
13.6.3.4	If the CCN extends the timeframe in accordance with 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 date the extension expires.	Full	Contract requirement met in CLINIC~2 document	
13.6.3.5	On the date the timeframe for	Full	Contract requirement met in CLINIC~2 document	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	service authorization expires.			
13.6.3.6	For expedited service authorization decisions where a provider indicates, or the CCN 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 CCN 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.	Full	Contract requirement met in CLINIC~2 document	
13.6.3.7	The CCN 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 CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	Contract requirement met in CLINIC~2 document	
13.6.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.	N/A		
13.7	**Resolution and Notification**			
13.7	The CCN must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition	N/A		

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	requires, within the timeframes established in 13.7.1 below.			
13.7.1	Specific Timeframes	N/A		
13.7.1.1	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 CCN receives the grievance.	Full	Addressed in Language in Member Grievance Resolution-LA_tc_docx_compliance edits.doc Dept Proc: Member Grievance Resolution	
13.7.1.2	Standard Resolution of Appeals. 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 CCN receives the appeal. This timeframe may be extended under 13.7.2 of this section.	Full	Addressed in Language in Member Appeals – core processes: Corporate Policy: Member Appeals – core Processes	
13.7.1.3	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 CCN receives the appeal. This timeframe may be extended under 13.7.2 of this Section.	Full	Addressed in Language in Member Appeals – core processes: Corporate Policy: Member Appeals – core Processes	
13.7.2	Extension of Timeframes. The CCN may extend the timeframes from 13.7.1 of this section by up to fourteen (14) calendar days if: the member requests the extension; or the CCN shows (to the satisfaction of DHH, upon its request) that there	Full	Addressed in Language in Member Appeals – core processes: Corporate Policy: Member Appeals – core Processes	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	is need for additional information and how the delay is in the member's interest. If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.			
13.7.3	Format of Notice of Disposition Grievances. DHH will specify the method the CCN will use to notify a member of the disposition of a grievance. Appeals. For all appeals, the CCN must provide written notice of disposition. For notice of an expedited resolution, the CCN must also make reasonable efforts to provide oral notice.	Full	Contract language in Member Appeals-Core Processes.doc	
13.7.4	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 CCN's action.	Full	Contract language in Member Appeals-Core Processes.doc	
13.7.5	Requirements for State Fair	N/A		

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Hearings The CCN shall comply with all requirements as outlined in this RFP.			
13.7.5.1	Availability. If the member has exhausted the CCN level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the CCN's notice of resolution.	Full	Contract language in Member Appeals-Core Processes.doc	
13.7.5.2	Parties. The parties to the State Fair Hearing include the CCN as well as the member and his or her representative or the representative of a deceased member's estate.	Full	Contract language in Member Appeals-Core Processes.doc	
13.8	**Expedited Resolution of Appeals**			
13.8.0	The CCN must establish and maintain an expedited review process for appeals, when the CCN 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.	Full	Contract language in Member Appeals-Core Processes.doc	
13.8.1	Prohibition Against Punitive Action	Full	Contract language in Member Appeals-Core	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	The CCN 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.		Processes.doc	
13.8.2	Action Following Denial of a Request for Expedited Resolution - If the CCN denies a request for expedited resolution of an appeal, it must: transfer the appeal to the timeframe for standard resolution in accordance with Section 13.7.1.2.; 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 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.	Full	Contract language in Member Appeals-Core Processes.doc	
13.8.3	Failure to Make a Timely Decision - Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the CCN'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	Full	Contract language in Member Appeals-Core Processes.doc	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	made.			
13.8.4	Process - The CCN 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. The CCN 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.	Full	Contract language in Member Appeals-Core Processes.doc	
13.8.5	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.	Full	Contract language in Member Appeals-Core Processes.doc	
13.8.6	Format of Resolution Notice - In addition to written notice, the CCN must also make reasonable effort to provide oral notice.	Full	Contract language in Member Appeals-Core Processes.doc	
13.9	**Continuation of Benefits**			
13.9.1	Terminology - As used in this	Full	Contract language in Member Appeals-Core	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the CCN mailing the notice of action. The intended effective date of the CCN's proposed action.		Processes.doc	
13.9.2	Continuation of Benefits - The CCN 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 the member requests extension of benefits.	Full	Contract language in Member Appeals-Core Processes.doc	
13.9.3	Duration of Continued or Reinstated Benefits - If, at the member's request, the CCN 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 CCN mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a	Full	Contract language in Member Appeals-Core Processes.doc	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.			
13.9.4	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 CCN's action, the CCN 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.	Full	Contract language in Member Appeals-Core Processes.doc	
13.10	**Information to Providers and Contractors**			
13.10	The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract.	Full	Information provided in April_2013_ProviderHandbook.pdf	
13.11	**Recordkeeping and Reporting Requirements**			
13.11	Reports of grievances and resolutions shall be submitted to DHH as specified in 13.4. The CCN shall not modify the grievance procedure without the prior written approval of DHH.	Substantial (Determination changed to "Full")	Monthly report in LA_EQRO_Monthly_Grievance_Reports.xls Is submitted annually to DHS per information provided at on-site visit.	MCO response: The plan disagrees with the Review determination. The plan has submitted required reports to DHH. The results should be Full IPRO response: Review determination is changed to "Full."

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
13.12	**Effectuation of Reversed Appeal Resolutions**			
13.12.1	Services not Furnished While the Appeal is Pending - If the CCN 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 CCN must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	Full	Contract requirement met in May 2013 Member Handbook ENG FINAL.pdf	
13.12.2	Services Furnished While the Appeal is Pending - If the CCN 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 CCN must pay for those services, in accordance with this Contract.	Full	Contract requirement met in May 2013 Member Handbook ENG FINAL.pdf	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**			
14.1.1	The CCN shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program to:	N/A		
14.1.1.1	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	Full	QM Program Description 2012 1.4 Goal, 1.5 Scope, 1.6 Objectives, 4 QM Process, 5 QM Work Plan, 6 QM Outcomes and Evaluation QM Program Description 2013 III Purpose, IV Goals, V Program Scope PIP Proposals and Reports Performance Measure Reports Statutory Reports PCP Quality Profiles QM Program Evaluation Report 2012 In addition, Amerigroup described an initiative to address gaps in care at its PCP offices. The plan identified the 30 largest practices that serve 80% of members. Individual practices are provided monthly reports of gaps in care for their patients, education, and assistance with patient outreach.	
14.1.1.2	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; and surveys	Full	QM Program Description 2012 4 QM Process, 5 QM Work Plan, 6 QM Outcomes and Evaluation QM Program Description 2013 VII Objectives of the QM Program, X Program Methodology, XI Key Program Initiatives QI Work Plan PIP Proposals and Reports Performance Measure Reports Medical Record Audit Reports Member Surveys – CAHPS Medicaid Adult, Child, CCC Provider Satisfaction Survey Results QM Program Evaluation Report 2012	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.1.1.3	Detect underutilization and overutilization of services	Full	QM Program Description 2012 1 Objectives, 4 QM Process, 5 QM Work Plan, 6 QM Outcomes and Evaluation QM Program Description 2013 VII Objectives of the QM Program, X Program Methodology, XI Key Program Initiatives Emergency Department Utilization PIP Proposal and Reports Geo Access Reports PCP Quality Profile Reports CMS 416 EPSDT Reports Performance Measure Reports HEDIS Reporting	
14.1.1.4	Assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Full	QMPD 2012 1 Objectives QM Program Description VII Objectives of the QI Program, XI Key Program Initiatives Quality initiative to address member identification and continuity of care after discharge from NICU. Amerigroup may find it useful to stratify its quality measure rates by category of aid (e.g., SSI, Foster) to identify and address gaps in care specific to special populations.	
14.1.2	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.	Full	QM Program Description 2012 1 Objectives, 4 QM Process, 5 QM Work Plan, 6 QM Outcomes and Evaluation QM Program Description 2013 VII Objectives of the QM Program, X Program Methodology, XI Key Program Initiatives QM Program Evaluation 2012 – Analysis of Diagnoses for high-volume episodes in ED, Outpatient and Inpatient settings ED Utilization PIP Proposal and Reports Quality initiative addressing continuity of care for members discharged from NICU Monitoring and analysis of sentinel events,	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			readmissions, and adverse events	
14.1.3	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.	Full	QM Program Description 2012 QM Program Description 2013 QM Program Evaluation 2012 – Analysis of Diagnoses for high-volume episodes in ED, Outpatient and Inpatient settings ED Utilization PIP Proposal and Reports Monitoring and analysis of sentinel events, readmissions, and adverse events	
14.1.4	The CCN shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed.	N/A		
14.1.5	The CCN's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the CCN'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 CCN.	Full	The Board of Directors delegates daily responsibility for the QM Program to the Quality Improvement Committee (QIC). The Board of Directors reviews and approves the QM Program Description 2012, QM Program Description 2013, and QM Program Evaluation 2012 as evidenced by the Board Representative approval signature.	
14.2	**QAPI Committee**			
14.2.1	The CCN shall form a QAPI Committee that shall, at a minimum include: QAPI Committee Members	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.1.1	The CCN Medical Director must serve as either the chairman or co-chairman;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.1.2	Appropriate CCN staff representing the various departments of the	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	organization will have membership on the committee; and		QMC Meeting Agendas and Minutes for 2012 and 2013 It is suggested that Amerigroup include committee member titles/organization/department in addition to names so that the participating departments and organizations is clear.	
14.2.1.3	The CCN is encouraged to include a member advocate representative on the QAPI Committee.	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A Amerigroup indicated that there is not an external member advocate participant on the committee, however, a representative from the marketing department, which communicates with members) does participate.	
14.2.2	QAPI Committee Responsibilities	N/A		
14.2.2.1	The committee shall meet on a quarterly basis;	Full	QM Program Description 2012 – 2 Program Structure Indicates that the committee will meet monthly. QM Program Description 2013 – Appendix A Indicates that the committee will meet monthly, at a minimum, 10 times annually. QMC Meeting Agendas and Minutes for 2012 and 2013 In 2012, the committee met 8 times which exceeds the requirement for quarterly meetings. In 2013, the committee met 5 times as of July 2013, which exceeds the requirement for quarterly meetings.	
14.2.2.2	Direct and review quality improvement (QI) activities;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.3	Assure than QAPI activities are implemented throughout the CCN;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.2.2.4	Review and suggest new and or improved QI activities;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.5	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.6	Designate evaluation and study design procedures;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.7	Conduct individual PCP and PCP practice quality performance measure profiling;	Full	Quality Profiles Reports	
14.2.2.8	Report findings to appropriate executive authority, staff, and departments within the CCN;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QM Meeting Agendas and Minutes for 2012 and 2013 Executive level staff members are members of the committee. Representatives from each of Amerigroup's operational departments are committee members.	
14.2.2.9	Direct and analyze periodic reviews of members' service utilization patterns;	Full	QM Program Description 2012 – 2 Program Structure QM Program Description 2013 – Appendix A QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.10	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH within ten (10) business days following each meeting;	Full	QMC Meeting Agendas and Minutes for 2012 and 2013	
14.2.2.11	Report an evaluation of the impact and effectiveness of the QAPI	Full	QM Program Evaluation Report 2012 QM Program Evaluation Report 2013	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	program to DHH annually. This report shall include, but is not limited to, all care management activities; and			
14.2.2.12	Ensure that a QAPI committee designee attends DHH Quality Committee meetings.	Full	Bayou Health Quality Committee meeting minutes attendance roster Bayou Health Quality Committee email distribution list	
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 from the date the Contract with DHH is signed by the CCN and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:	Full	QAPI Work Plan The Board of Directors reviews and approves the QM Program Description and QI Work Plan as evidenced by the Board Representative approval signature. Submitted to DHH for Readiness Review. Email submission of QI Work Plan submitted to DHH on 2/28/2013. Attestation for QI Work Plan dated 2/28/2013.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	Full	QM Program Description 2012 4 QM Process, 5 Work Plan, 6 QM Reporting Outcome and Evaluation QM Program Description 2013 X Program Methodology QI Work Plan	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	Full	QM Program Description 2012 4 QM Process, 5 Work Plan, 6 QM Reporting Outcome and Evaluation QM Program Description 2013 X Program Methodology, XV Quality Improvement Annual Evaluation QI Work Plan	
14.2.3.3	Include a description of the CCN staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	Substantial	This is not contained in the QI Work Plan; it is contained in the QM Program Description. QM Program Description 2012 – 3 Organizational Structure QM Program Description 2013 – Appendix B	MCO response: The plan will address in the 2014 QM Program Description. IPRO response: Review determination is unchanged. Updated QM

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			The 2013 program description differs in format and content from the 2012 version. The 2012 version provides a more detailed description of the staff and departments, the specific qualifications/training, organization, and responsibilities. The 2013 provides detailed information for the Senior Executive, Medical Director, and Behavioral Health Medical Director and the Quality Management Department as a whole (no qualifications/training specified). Amerigroup should consider including more of the detailed information provided in the 2012 version in its upcoming 2014 QM Program Description.	Program Description will be reviewed as part of next year's audit.
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program.	Full	This is not contained in the QI Work Plan; it is contained in the QM Program Description. QM Program Description 2012 QM Program Description 2013 – 3 Organizational Structure, 3.11 Participating Providers Evidence of provider input in the QM program was seen in the committee meeting minutes. Amerigroup described a collaborative initiative with its PCP groups. Gap reports have been shared and 10 pilot provider groups were targeted for onsite visits. During the visits, Amerigroup representatives discuss the reports and offer assistance with improvement activities including outreaching members, educating members on prevention and management of chronic conditions. This initiative has been well received and Amerigroup plans on continuing and expanding it across all GSAs.	
14.2.4	QAPI Reporting Requirements: The CCN shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities;	Full	QM Program Evaluation 2012 QM Program Evaluation 2013 – Attestation dated 3/29/2013, email submission 3/29/2013	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Recommended new and/or improved QI activities; and Evaluation of the impact and effectiveness of the QAPI program.			
14.3	**Performance Measures**			
14.3.1	The CCN 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 CCN Quality Companion Guide.	Full	PQ217 QAPI Early Warning System Performance Measures Report - Attestation dated 7/30/2013, email submission to DHH dated 7/29/2013 P180 Quality Profiles Reports – quarterly submissions 2012	
14.3.1.1	The CCN is required to report on PMs listed in Appendix J which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consume Assessment of Healthcare Providers and Systems (CAHPS) measures, and/or other measures as determined by DHH.	Full	PQ217 QAPI Early Warning System Performance Measures Report P180 Quality Profiles Reports – quarterly submissions CAHPS Survey Reports – Adult, Child, CCC populations by Morpace AHRQ measures, CHIPRA measures and State-specific measures pending reporting in 2014	
14.3.1.2	The CCN shall have processes in place to monitor and self-report all performance measures.	Full	Overview of Systems Utilized in Amerigroup Processing Procedures PQ217 QAPI Early Warning System Performance Measures Report P180 Quality Profiles Reports – quarterly submissions QM Program Description 2012 QM Program Description 2013 QM Work Plan QM Program Evaluation 2012	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			QM Program Evaluation 2013	
14.3.1.3	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	Full	PQ217 QAPI Early Warning System Performance Measures Reports P180 Quality Profiles Reports – quarterly submissions	
14.3.1.4	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	Full	Amerigroup indicated that Administrative Performance measures are reported to DHH every 6 months.	
14.3.1.5	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Full	PQ217 QAPI Early Warning System Performance Measures Report P180 Quality Profiles Reports – quarterly submissions QM Program Evaluation 2012 QM Program Evaluation 2013	
14.3.2	Incentive Based Performance Measures	N/A		
14.3.2.1	Incentive Based (IB) measures are Level I measures that may affect PMPM payments and can be identified in Appendix J annotated with "$".	N/A	Definition	
14.3.2.2	Based on a CCN's Performance Measure outcomes for CYE 12/31/2013, a maximum of 2.5% (0.5% for each of 5 specific IB measures) of the total monthly capitation payments may be deducted effective October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.	N/A	Contract provision	
14.3.2.3	DHH expressly reserves the right to modify existing performance IB	N/A	Contract provision	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide sixty (60) days notice of such change.			
14.3.3	Performance Reporting Measures	N/A		
14.3.3.1	All Administrative, Level I and Level II PMs are reporting measures. • Administrative measure reporting is required semiannually and upon DHH request. • Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012. • Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012. • Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012. • Level I and Level II PM reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.	Full	Reporting Schedule Administrative and Prevention Quality measures reported as required (see previous elements: 14.3.1)	
14.3.3.2	DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.	N/A	Contract provision	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.3.4	Performance Measure Goals	N/A		
14.3.4.1	The Department will establish benchmarks for Incentive Based and Level I Performance measures utilizing statewide data of the Medicaid Fee for Service Population for CY 2011 with the expectation that performance improves by a certain percentage.	N/A	DHH responsibility	
14.3.4.2	Statewide goals will be set for 2015 Level II Performance Measure utilizing an average of all CCNs outcomes received in 2014 for the 2013 measurement year.	N/A	DHH responsibility 2015	
14.3.5	Performance Measure Reporting	N/A		
14.3.5.1	The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Full	Overview of Systems Utilized in Amerigroup Processing Procedures QM Program Description 2012 – 4 QM Process, 6 QM Outcome and Evaluation QM Program Description 2013 – X Program Methodology	
14.3.5.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.	Full	Reports submitted compliant with the DHH required formats and content.	
14.3.5.3	The CCN shall have processes in place to monitor and self-report performance measures as specified in §14.3.3 Reporting Measures.	Full	Overview of Systems Utilized in Amerigroup Processing Procedures QM Program Description 2012 – 4 QM Process, 6 QM Outcome and Evaluation QM Program Description 2013 – X Program Methodology	
14.3.5.4	The CCN shall provide individual PCP clinical quality profile reports as	Full	PQ217 QAPI Early Warning System Performance Measures Report	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	indicated in §8.22 PCP Utilization and Quality Reporting.		P180 Quality Profiles Reports – quarterly submissions	
14.3.6	Performance Measure Monitoring	N/A		
14.3.6.1	DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.	N/A	DHH responsibility	
14.3.6.2	During the course of the Contract, DHH or its designee will actively participate with the CCN to review the results of performance measures.	N/A	DHH responsibility – Performance Measure validation pending	
14.3.6.3	The CCN shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to CCN members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.	Full	Amerigroup submitted all requested documentation for the Annual Compliance Review and cooperated and actively participated in the onsite review.	
14.3.6.4	The standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within	N/A	This is the first Annual Compliance Review with findings pending.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the CCN's progress in correcting the deficiencies.			
14.3.7	Performance Measure Corrective Action Plan A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.	Full	No CAP has been required based on Amerigroup's Performance Measure reporting	
14.3.7.1	The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.	Full	No CAP has been required based on Amerigroup's Performance Measure reporting	
14.3.7.2	Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the CCN shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.	N/A	No CAP has been required based on Amerigroup's Performance Measure reporting	
14.3.7.3	Upon approval of the CAP, whether the initial CAP or the revised CAP, the CCN shall implement the CAP within the time frames specified by DHH.	N/A	No CAP has been required based on Amerigroup's Performance Measure reporting	
14.3.7.4	DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	N/A	Contract provision	
14.3.8	Performance Improvement Projects	N/A		

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.3.8.1	The CCN shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240.	Full	QM Program Description 2012 – 1.6 Objectives QM Program Description 2013 – VII Objective of the QM Program PIP Proposals and Interim Reports	
14.3.8.2	The CCN shall perform a minimum of two (2) DHH approved PIPs in the first Contract year. The DHH required PIP during the first Contract year is listed in Section 1 of Appendix DD - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of Appendix DD. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.	Full	PIP Proposals and Interim Reports EQRO Feedback on PIP Proposals and Interim Reports	
14.3.8.3	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 PIP must involve the following: • Measurement of performance using 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.	Full	PIP Proposals and Interim Reports EQRO Feedback on PIP Proposals and Interim Reports	
14.3.8.4	Within three (3) months of the execution of the Contract and at the	Full	PIP Proposals and Interim Reports	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	beginning of each Contract year thereafter, the CCN shall submit, in writing, a general and a detailed description of each PIP to DHH for approval. The detailed PIP description shall include: • An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers; • The study question; The study population; • The quantifiable measures to be used, including a goal or benchmark; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection cycle; • Data analysis cycle and plan; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Analysis and identification of opportunities for improvement; and • An explanation of all interventions to be taken.		EQRO Feedback on PIP Proposals and Interim Reports P130 QAPI Performance Improvement Projects (Descriptions) dated 5/30/2012	
14.3.8.5	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	Full	PIP Proposals and Interim Reports EQRO Feedback on PIP Proposals and Interim Reports P130 QAPI Performance Improvement Projects (Descriptions) dated 5/30/2012	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	practice guidelines to objectively evaluate the care the CCN 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; • 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 appropriate health professionals analyze data; • 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			

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	issues over time to ensure that actions for improvement are effective.			
14.3.8.6	DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The CCN shall report the status and results of each PIP as specified in the Quality Companion Guide.	Full	Amerigroup has reported the status of its PIPs at the proposal and interim reporting phases as required by DHH.	
14.3.8.7	If CMS specifies Performance Improvement Projects, the CCN will participate and this will count toward the state-approved PIPs.	N/A	No PIPS specified by CMS	
14.3.8.8	Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.	Full	PIPs progressing as expected per: PIP Proposals and Interim Reports EQRO Feedback on PIP Proposals and Interim Reports	
14.3.9	PIP Reporting Requirements	N/A		
14.3.9.1	The CCN shall submit PIP outcomes annually to DHH.	Full	PIP Proposals and Interim Reports EQRO Feedback on PIP Proposals and Interim Reports P130 QAPI Performance Improvement Projects (Descriptions) dated 5/30/2012	
14.3.9.2	Reporting specifications are detailed in the Quality Companion Guide.	N/A	Contract provision	
14.3.9.3	DHH reserves the right to request additional reports as deemed	N/A	No additional reports requested	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports.			
14.4	**Member Satisfaction Surveys**			
14.4.1	The CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace Amerigroup indicated that "Getting Needed Care" was identified as a priority area for improvement. It was suggested that the plan might initiate a member focus group, telephone survey, or use other member points of contact to solicit specific information on areas of concern. Amerigroup indicated that outreach calls are currently used to obtain some information on satisfaction with PCPs.	
14.4.2	The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.	Full	Letter from Morpace dated 4/24/2013 Morpace is listed on the NCQA website as a certified CAHPS survey vendor.	
14.4.2.1	The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.3	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.4	The CAHPS survey results shall be reported separately for each CCN GSA. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the CCN at the time of the survey.	N/A	Reporting of results by GSA was not required of MCOs. The NCQA-certified CAHPS survey vendor, Morpace, follows the CAHPS survey technical specifications and ensures that the survey samples are statistically valid.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.4.5	The surveys shall provide valid and reliable data for results in the specific CCN GSA.	N/A	Reporting of results by GSA was not required of MCOs.	
14.4.6	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.7	The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include:	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace QM Department Procedure: CAHPS Member Satisfaction Survey, 7/15/2013 indicates that the CAHPS 4.0 surveys will be used as stipulated here, however, CAHPS 5.0 is the most recent version. The Amerigroup CAHPS reports do not specifically note the survey version. Amerigroup should confirm the survey version used and ensure it is the most recent.	
14.4.7.1	Getting Needed Care	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.7.2	Getting Care Quickly	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.7.3	How Well Doctors Communicate	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.7.4	Health Plan Customer Service	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.7.5	Global Ratings	Full	CAHPS Medicaid Survey Reports for Adult, Child, and CCC populations – Morpace	
14.4.8	Member Satisfaction Survey Reports are due 120 days after the end of the plan year.	N/A		
14.5	**Provider Satisfaction Surveys**			
14.5.1	The CCN shall conduct an annual provider survey to assess	Full	Provider Satisfaction Survey Report – Morpace	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.		QM Evaluation 2012 Corporate Amerigroup 2012 Provider Satisfaction Survey Results and 2013 Action Items/Plans Amerigroup has noted a very low and declining response rate for its Provider Satisfaction Survey locally and corporate-wide. It was suggested, if allowed, that offering a small incentive for survey return might help to increase response rates.	
14.5.1.1	The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	Full	Provider Satisfaction Survey Report – Morpace	
14.5.2	The CCN shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	Full	Provider Satisfaction Survey Report – Morpace	
14.6	**DHH Oversight of Quality**			
14.6.1	DHH shall evaluate the CCN's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.	N/A	DHH responsibility	
14.6.2	If DHH determines that the CCN's quality performance is not acceptable, DHH will require the CCN to submit a corrective action plan (CAP) for each unacceptable performance measure. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the	N/A	No CAP has been issued based on Amerigroup's quality performance	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and automatic assignments.			
14.6.3	Upon any indication that the CCN's quality performance is not acceptable, DHH may restrict the CCN's enrollment activities including, but not limited to, termination of automatic assignments.	N/A	No has been issued based on Amerigroup's quality performance No enrollment restrictions	
14.6.4	When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the CCN's cumulative performance on all quality improvement activities.	N/A	Contract provision	
14.6.5	The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.	Full	Amerigroup has cooperated and actively participated in the monitoring process.	
14.7	**External Independent Review**			
14.7.1	The CCN shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.	Full	Amerigroup submitted all requested documentation for the Annual Compliance Review and other EQR activities.	
14.7.2	The CCN shall cooperate with the EQRO during the review (including medical records review), which will	Full	Amerigroup has cooperated with the EQR review activities.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	be done at least one (1) time per year.			
14.7.3	If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN in accordance with the provisions of § 20 of the Contract and may immediately terminate all enrollment activities and automatic assignment until the CCN attains a satisfactory level of quality of care as determined by the EQRO.	N/A	First Annual EQR Technical Report pending No findings regarding quality of care based on other EQR activities.	
14.7.4	A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the CCN's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQRO.	N/A	First Annual EQR Technical Report pending	
14.8	**Health Plan Accreditation**			
14.8.1	The CCN must attain health plan accreditation by NCQA or URAC. If the CCN is not currently accredited by NCQA or URAC, the CCN must attain accreditation by meeting NCQA or URAC's accreditation standards.	Full	Amerigroup has earned NCQA New Health Plan Accreditation	
14.8.2	The CCN's application for accreditation must be submitted at the earliest point allowed by the organization. The CCN must provide DHH with a copy of all correspondence with NCQA or URAC regarding the application	Full	Amerigroup has earned NCQA New Health Plan Accreditation	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	process and the accreditation requirements.			
14.8.3	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 or URAC accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	N/A	Amerigroup has earned NCQA New Health Plan Accreditation	
14.9	**Credentialing and Re-credentialing of Providers and Clinical Staff**			
14.9.1	The CCN must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 and NCQA health plan Accreditation Standards for the review and 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.	Full	Corporate Policy: Credentialing and Recredentialing for Licensed Independent Practitioners, May 21. 2013 Corporate Policy: Credentialing and Ongoing Assessment of Organizational Providers (Facilities and Ancillary Providers), July 17, 2013 Corporate Policy: Roles and Responsibilities of the Medical Directors and Credentialing Committees August 15, 2012 Credentialing File Review: 10 PCP Initial Credentialing files were reviewed and met all requirements. 10 Specialist Initial Credentialing files were reviewed and met all requirements. It was noted that office site visits are not conducted as part of the credentialing process for PCPs since it is not required by NCQA Standards for Accreditation and not specified in the State contract. Amerigroup may wish to consider conducting site visits for PCP credentialing, as this can be considered a best practice. In addition, there was a member complaint regarding provider office conditions. The plan conducted appropriate follow-up for this issue, however, had an	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			initial site visit been conducted, this could have been avoided.	
14.9.1.1	The CCN shall use the state's standardized credentialing form (see Appendix F – Louisiana Standardized Credentialing Application Form).	Full	Credentialing file review confirmed use of the Louisiana standardized credentialing form.	
14.9.1.2	An independent relationship exists when the CCN selects and directs it members to see a specific provider or group of providers.	N/A	Definition	
14.9.1.3	These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.	Full	Submitted to DHH for Readiness Review	
14.9.2	The process for periodic re-credentialing shall be implemented at least once every three (3) years.	Full	Corporate Policy: Credentialing and Recredentialing for Licensed Independent Practitioners, May 21, 2013	
14.9.3	If the CCN is not NCQA health plan accredited and has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The CCN must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.	Substantial	The following organizations conduct delegated credentialing: Block Vision Children's Health Network Eyequest Health Services of N Louisiana LSU Ochsner Teladoc Tulane Willis Knighton A description of the delegated credentialing activities and subcontractor assurance that professionals are credentialed in accordance with DHH's credentialing requirements was found in all delegate contracts except Children's Health Network and Willis Knighton.	MCO response: The plan disagrees with this review determination. We are accredited by NCQA.  NCQA Cert. 2013.docx IPRO response: Determination is unchanged. The "Substantial" rating was assigned based on the two credentialing entities for which there was no evidence that DHH credentialing requirements were followed.
14.9.4	If the CCN has NCQA health plan Accreditation those credentialing	Full	Amerigroup has earned NCQA New Health Plan Accreditation	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	policies and procedures shall meet DHH's credentialing requirements.			
14.9.5	The CCN 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.	Full	Corporate Policy: Credentialing and Recredentialing for Licensed Independent Practitioners, May 21, 2013 Provider Discipline and Credentialing Appeal Rights, July 17, 2013 Corporate Policy: Credentialing and Recredentialing for Licensed Independent Practitioners, May 21, 2013 states that practitioners are expected to be board certified or to have completed a residency appropriate for their stated specialty.	
14.9.6	The CCN shall develop and implement a mechanism, with DHH's 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.	Full	Corporate Policy: Provider Discipline and Credentialing Appeal Rights, July 17, 2013 Corporate Policy: Reporting Authority and Requirements, March 20, 2013 Amerigroup indicated that no providers had been suspended or terminated for quality deficiencies.	
14.9.7	The CCN shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the CCN 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.	Full	Corporate Policy: Provider Discipline and Credentialing Appeal Rights, July 17, 2013 Corporate Policy: Reporting Authority and Requirements, March 20, 2013 Corporate Policy: Government Sanction Notification and Ongoing Sanctions Monitoring, May 14, 2013 Department Procedure: Peer Review – LA, January 17, 2013 Amerigroup indicated that this has not occurred to date, however, credentialing was discontinued and network privileges were denied to one provider due to not providing malpractice insurance information.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
14.10	**Member Advisory Council**			
14.10.1	The CCN 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.	Substantial	Report P141 Member Advisory Council Subsequent Plan, 12/27/2012 Member Advisory Council Charter QM Program Description 2012 – 2 Program Structure The Member Advisory Council was not included in the QM Program Description 2013 – Appendix A (committee descriptions). Amerigroup should add this to Appendix B for the 2014 version.	MCO response: The plan will include address in the 2014 QM Program description. IPRO response: Review determination is unchanged. The 2014 Program Description will be reviewed as part of next year's audit.
14.10.2	The Council is to be chaired by the CCN's Administrator/CEO/COO or designee and will meet at least quarterly.	Full	Report P141 Member Advisory Council Subsequent Plan, 12/27/2012 Member Advisory Council Charter Member Advisory Committee Meeting Agendas and Minutes 2012, 2013 In 2012, the committee met 8 times, which exceeds the quarterly requirement.	
14.10.3	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. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Full	Report P141 Member Advisory Council Subsequent Plan, 12/27/2012 Member Advisory Council Charter AMERIGROUP LOUISIANA ADVISORY COMMITTEE COMMITTEE MEMBER LIST, OCTOBER 2011 REVISED: August 21, 2013 The majority of the membership (> 50%) is comprised of Member Advocates. However, no members or family members were noted as members. Amerigroup continues to actively recruit members to participate and indicated that a member's foster parent has been recruited. Suggestions on recruitment strategies and varied	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			means for members to participate were discussed as possibilities.	
14.10.4	The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Full	Amerigroup Louisiana Advisory Committee October 19 Meeting Notes	
14.10.5	The CCN 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 by December 15th.	Full	Report P141 Member Advisory Council Subsequent Plan, 12/27/2012 Member Advisory Council Charter	
14.10.6	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.	Full	Report P139 Member Advisory Council (minutes summary) Also note that DHH staff members are committee members. A screen shot showing the listing of Member Advisory Council minutes was provided as evidence that the minutes were posted.	

Reporting				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
18.0	**Reporting**			
18.0	The CCN shall comply with all the reporting requirements established by this Contract. As per 42 CFR §438.242(a)(b)(1)(2) and (3), The CCN 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 CCN shall collect data on member and provider characteristics and on services furnished to members. The CCN shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation. The CCN shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed. In the event that there are no instances to report, the CCN shall	Full	The plan utilizes various health information systems for various functions, i.e. • Macess • Facets • PEGA • Care Compass • Quality of Care Database • Amerigroup internal monitoring tool – SharePoint • SalesForce • Emptoris • Cactus • Encounter Pro • PeopleSoft • WorkNet – transition to WellPoint internal systems • Atlas The plan submitted the Process and Responsibilities for the Development, Review and Submission of Regulatory Reports P/P which details the plan's process to ensure consistency and accountability in the development and submission of all state required regulatory reports. The plan also submitted a spreadsheet which details all of the reports they are required to submit to DHH, the business function it is relevant to, the "owner" of the report, the status of the report, deadline, comments including updates to the report as requested by the DHH.	

Reporting				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	submit a report so stating. As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, the CCN shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification. The data shall be certified by one of the following: •CCN's Chief Executive Officer (CEO); •CCN's Chief Financial Officer (CFO); or •An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.			