Amerihealth Caritas of Louisiana

2020 Compliance Audit

Review Period: April 01, 2019 – March 31, 2020

Final Report Issued February 2021

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

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Introduction and Audit Overview

Introduction

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

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct annual compliance audits every three years. The 2020 annual compliance audit was a partial audit of the MCO's compliance with contractual requirements during the period of April 1, 2019, through March 31, 2020. Requirements that were not fully compliant in the full 2019 annual compliance audit were reviewed.

This report presents IPRO's findings of the 2020 annual compliance audit for Amerihealth Caritas of Louisiana (ACLA).

Audit Overview

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

The partial audit included an evaluation of ACLA's policies, procedures, files, and other materials corresponding to the following five contractual domains:

1. Marketing and Member Education
2. Provider Network Requirements
3. Quality Management
4. Core Benefits and Services
5. Reporting

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

ACLA's partial review did not include file review.

The period of review was April 1, 2019, through March 31, 2020. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "not applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 1**.

Table 1: Review Determination Definitions

Review Determination	Definition
Full	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard, but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not applicable	The requirement was not applicable to the MCO.

The 2020 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) video interviews, and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared five review tools to reflect the areas for audit. These five tools were submitted to the LDH for approval at the outset of the audit process on April 8, 2020. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the MCO on July 1, 2020, in advance of the onsite audit.

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

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

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

After the MCO submitted the required documentation, a team of seven IPRO auditors was convened to review the MCO's policies, procedures, and materials, and to assess the MCO's concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the video interviews.

Video Interviews

The video interview component of the audit was conducted on September 3, 2020. Interviews discussed elements in each of the five review tools that were considered less than fully compliant based upon review. Interviews were used to further explore the written documentation and to allow the MCO to provide additional documentation, if available. MCO staff were given two days from the close of the onsite review to provide any further documentation.

Post-onsite Report Preparation

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

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

After receiving the MCO's response, IPRO re-reviewed each element for which the MCO provided a response. As necessary, review scores were updated based on the response of the MCO.

MCO Summary of Findings

Summary of Findings

Table 2 provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Please note this is a partial review. This table excludes full items from the prior review. Total compliance for each tool (including full items from prior year) will be higher for domains scoring less than 100%. Additionally, some items were new requirements for this review which may have impacted overall percentages.

Table 2: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Marketing and Member Education	2	2	0	0	0	0	100%
Provider Network Requirements	21	10	10	1	0	0	48%
Quality Management	1	1	0	0	0	0	100%
Core Benefits and Services	6	5	1	0	0	0	83%
Reporting	1	1	0	0	0	0	100%
Total	**31**	**19**	**11**	**1**	**0**	**0**	**61%**

[1] N/As are not included in the calculation.

As presented in **Table 3**, 31 elements were reviewed for compliance. Of the 31 elements, 19 were determined to fully meet the regulations, while 11 substantially met the regulations, 1 minimally met the regulations, and 0 were determined to be non-compliant. Zero elements were "not applicable." The overall compliance score indicates that 61% of regulations not fully compliant in the prior review have been addressed by the MCO and are now fully compliant.

IPRO extracted from each of the five detailed reports those elements for which the MCO was found to be less than fully compliant. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, the MCO's initial response, and, when possible, suggestions to achieve full compliance.

It is the expectation of LDH that ACLA submits a corrective action plan for new elements determined to be less than fully compliant.

Each of the five review tools and review determinations for each of the elements follow **Table 3**.

Table 3: Deficient 2020 Audit Elements

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.16	**Sterilization**					
6.16.2	Sterilization must be conducted in accordance with Louisiana R.S. 40:1159.2, state Medicaid policy, federal regulations contained in 42 CFR §441.250 - 441.259. All procedures must be documented with a completed Sterilization Consent Form OMB 0937-0166.	P/P Sterilization Services Member Handbook/website Provider Manual/portal	New requirement	Substantial	This requirement is partially addressed in the Provider Handbook on pages 73-74, and in the Consent for Sterilization form; however, there is no sterilization policy document to support that sterilization is conducted in accordance with federal regulations 441.253 Sterilization of a mentally competent individual aged 21 or older and 441.254 Mentally incompetent or institutionalized individuals. In addition, the Member Handbook does not inform the member about this service. **Recommendation** The MCE should develop a sterilization policy that addresses these requirements, and to include corresponding benefit language in the Member Handbook. In follow-up, the MCE provided a Sterilization Policy effective 9/2/20 that	ACLA Corrective Action Plan: To ensure that the sterilization policy and member handbook are updated to include that sterilization is conducted in accordance with federal regulations 441.253 and 441.254. These updates have been made. Attached for your review are the updated sterilization policy and member handbook information.

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					meets this requirement for the next compliance review year. The MCE also indicated that the Member Handbook will be updated.	
7.1	**General Provider Network Requirements**					
7.1.4	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Substantial This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendation** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	Substantial	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendation** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	See Section 7.3.1 below.
7.3						
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendation** See recommendations for individual requirements in section 7.3. **MCO Response** Please see all responses below	Substantial	This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendation** See recommendations for individual requirements in section 7.3.	See Section 7.3.1 below.

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	MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.		that are responsive to this element.			
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 3. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to PCPs for their urban members. **MCO Response** The requirement as stated in 7.3 and the Provider Network Companion guide is, "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.9% of	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. **Recommendation** The MCE should improve access to PCPs for their urban members.	ACLA's network is open to PCPs who request to join and those the Account Executives (AEs) actively recruit. The AEs are aware of the urban parishes that have gaps for PCPs who treat adults - (Cameron for 9 members, Plaquemines for 81 members and Terrebonne for 13 members) and are working to recruit in these areas. The AEs are aware of the urban parishes that have gaps for PCPs who treat pediatrics - (Cameron for 15 mbrs and

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			members in urban areas have access to an Adult or Pediatric PCP within the 20-minute requirement. ACLA is open to adding PCPs as providers' request. ACLA is currently outreaching providers who have been exclusively signed up with one or two health plans to add them to the network.			Plaquemines for 94 mbrs) and are working to recruit in these areas. ACLA initiated a contract effective May 2020 with a provider who provides PCP access and/or care coordination with member's assigned PCP. ACLA has discussed expanding their services to include Plaquemines and perhaps Terrebonne. Provider is in agreement and negotiations are in progress. ACLA currently has an initiative to recruit providers who have historically only accepted Medicare or commercial payors. This involves a tiered approach with an

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						introductory letter with an attached contract template and PNM Director's contact information. The AE will follow up with a phone call within 30 days. An introductory meeting is offered to allow the provider to ask questions and concerns about the reimbursement rates. This is also an opportunity for the provider to propose any alternate payment models such as bundled or shared savings plans. In addition, the AEs continue to outreach par PCPs and large groups to expand services or open panels that may be closed due to meeting capacity. The AEs

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						are educating the providers regarding alternate payment models to encourage par providers to keep panels open and to recruit new providers. Account Executives have been provided with a copy of the Report 220 and this analysis. They are reviewing a monthly Network Adequacy report and targeting provider outreach in the areas of need.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals .1 Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. .2 Travel distance for members	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. ACLA is contracted with all acute hospitals in Louisiana.	

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	living in urban parishes shall not exceed 10 miles.		urban parishes. **MCO Response** The requirement as stated in 7.3 and the Provider Network Companion guide is, "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.1% of the members in urban parishes have access to an acute hospital within the 20-minute requirement. ACLA is contracted with all acute inpatient hospitals at this time. See the attached PH Network Development Service document in the row above.		The state is considering whether it is appropriate to modify its contract requirements.	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services .1 Travel distance shall not exceed 20 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes.	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are not met for urban lab and urban radiology parishes (Plaquemines). **Recommendation** The MCE should improve member access to lab and	There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA meets all access requirements when these access points are considered.

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			Recommendation The MCO should improve member access to lab and radiology services in urban parishes. The MCO has indicated that the Geo Access Report only includes stand-alone lab and radiology services and that more lab and radiology services are provided to members that are not counted in the geo access report. **MCO Response** There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA is also contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician office which increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing.		radiology services in urban parishes.	Note that labs in these settings do not have unique NPI or tax ID numbers in order to be captured separate from the group type for reporting purposes. ACLA is contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician office which increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing. Quest and LabCorps are the two largest and they cover the entire state by using courier services for pick up at physician offices. When all

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						draw sites for these two labs alone are considered, 100% of members in urban and rural parishes have access within the required standards.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1 Travel distance shall not exceed 10 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve member access to pharmacies in urban parishes. **MCO Response** ACLA is currently contracted with 1,182 pharmacy locations in Louisiana. Per NCPDP, there are currently nine pharmacies in the parishes with gaps (three in Plaquemines and six in Union). ACLA is contracted with all nine.	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance requirement are not met for urban pharmacy parishes. **Recommendation** The MCE should improve member access to pharmacies in urban parishes.	PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provide access to retail and specialty pharmacy providers. There are currently only three pharmacies which operate in Plaquemines Parish which has the largest gap and ACLA is contracted with all three. Cameron Parish in Region 5 has a gap; however, there are no pharmacies in this parish for ACLA to contract with.

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			ACLA is contracted with 71 pharmacies in Region 5 and 213 in Region 1. Only 0.1% of the enrollees in urban parishes do not have access within 20 minutes. Enrollees in all urban parishes, with the exception of Cameron and Plaquemines, have a drive time within 20 minutes to a pharmacy. AmeriHealth Caritas' PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provides access to retail and specialty pharmacy providers.			ACLA is contracted with 71 pharmacies in Region 5. Therefore, there are no additional pharmacies with whom ACLA can add to the network. Consideration may include a joint effort with LDH and the other MCO(s) to address the needs and discuss solutions.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1 Travel distance shall not exceed 10 miles in urban areas; and .3 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Minimal This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for some rural parishes and most urban parishes. **Recommendation** The MCO should improve member access to hemodialysis centers in rural parishes and	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance requirements are not met for urban parishes. **Recommendation** The MCE should improve member access to hemodialysis centers in urban parishes.	ACLA will determine if there are any dialysis providers in La. who are not currently contracted and attempt to recruit these providers into the network. This will be an initiative to start in Quarter 4 of 2020. Introductory meetings will be offered with these providers to discuss any options of

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			especially in urban parishes. **MCO Response** Only 1.8% of the enrollees in urban parishes drive more than 20 minutes to this provider type. Among nine urban parishes in Regions 1, 2, 3, 5, 6, and 7, more than 90% of the enrollees have access within the required driving time. These include Bossier, Caddo, Calcasieu, De Soto, Pointe Coupee, Rapides, St. Bernard, Terrebonne and West Feliciana. The largest percentage of enrollees who drive more than the maximum standard reside in Cameron (Region 5), Grant (Region 6), Lafourche (Region 3), Plaquemines (Region 1), and Union (Region 8) parishes. ACLA is working with providers to expand this level of care. There are 178 providers to date. Two new centers were added to ACLA's network in Quarter 2 2019 in Regions 1 and 6. ACLA continues to work with large providers, i.e. Fresenius, to increase access to these centers.			interest that the provider may have or concerns. This is an opportunity for the provider to agree to the Medicaid rates or discuss alternate rates that would allow them to join the ACLA network.
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for	Network Provider Development and Management Plan P/P for Access and	Substantial This requirement is addressed in Provider Availability Standards	Substantial	This requirement is addressed in BH Network Gap Analysis-2020 Q1.	ACLA will run the list of SU Residential providers from the

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	admission or appointment shall not exceed 10 business days.	Availability GeoAccess reports Requests for exceptions	Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendation** The MCO should improve member access to ASAM level 3.3. The MCO should record and report admission or appointment times for ASAM level 3.3 **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met,LDH has confirmed that MCOs were not required to report admission or appointment times. **MCO Response** Statutory report 359, Measurement 2, addressed the minimum performance thresholds for time of admission		Distance and/or time requirements are not met for urban and rural parishes. **Recommendation** The MCE should improve member access to ASAM level 3.3.	La. Health Standards Section and target the non-par providers for recruitment during Q4 2020. Three AEs will be assigned to outreach targeted providers. Meetings will be offered to address providers' questions, concerns and payment structure requests since many of these currently only accept private or commercial pay.

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			or appointment but this was never required and discontinued July 2018. ACLA continues to encourage these provider types to enter the ACLA network. ACLA has reached an agreement with Acadia Healthcare for ASAM Residential for adults and adolescents. ACLA completed contracting and credentialing for a new entity Substance Use Residential program and for existing sites with Addiction Recovery Resources which involved a change of ownership for 3 sites in Metairie and one site in Destrehan, La. These are referenced as Avenues Recovery. ACLA is also working on contracting with a Substance Residential Provider who has historically only accepted commercial pay in the New Orleans area. ACLA completed a project involving outreach to all network Substance Use providers to verify ASAM levels as these provider types added capacity and/or locations without notifying ACLA. Work requests to add or change ASAM levels is in progress. One provider in Ruston became			

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			credentialed adding SU Residential services. ACLA is contracted with all Opioid Treatment Program providers with the exception of Choices who has not yet submitted a packet. See BH report above.			
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendation** The MCO should improve member access to ASAM level 3.5. The MCO should also record and report admission or appointment times for ASAM level 3.5. **Final Review Determination** Review determination changed to substantial. While time and	Substantial	This requirement is addressed in BH Network Gap Analysis-2020 Q1. Distance and/or time requirements are not met for urban and rural parishes. **Recommendation** The MCE should improve member access to ASAM level 3.5.	ACLA will run the list of SU Residential providers from the La. Health Standards Section and target the non-par providers for recruitment during Q4 2020. Three AEs will be assigned to outreach target providers. Meetings will be offered to address providers' questions, concerns and payment structure requests since many of these currently only accept private or commercial pay.

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			distance standards are not met, LDH has confirmed that MCOs were not required to report admission or appointment times. **MCO Response** Same feedback as above.			
7.8.3	**Specialty Providers**					
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider types	Substantial This requirement is addressed in section 7.3, Geographic Access Requirements. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. **Recommendation** The MCO should improve member access to urban and rural parishes. **MCO Response** See above response.	Substantial	This requirement is addressed in section 7.3, Geographic Access Requirements. A review of geographic access reports indicates that time and/or distance requirements are not met for all urban and rural parishes. **Recommendation** The MCE should improve member access to urban and rural parishes.	ACLA will continue to work with our existing provider systems to gain greater access of specialists in parishes where gaps exist and collaborate with healthcare systems to increase access in Vernon and Beauregard parishes. ACLA has initiated an updated recruitment process to include provider letters, flier and a brief

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
						presentation. Currently, the team is working on requested alternate payment models (APM) for potential providers who will only consider enhanced rates with an APM option. ACLA will focus on adding specialists in Plaquemines Parish by working to add telemedicine and expanding new programs that were implemented in 2019, such as Ready Responders. Ready Responders is a treat-in-place program whereas members can be seen in the

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
						community including their home when their PCP is not available impromptu. This program offers medical triage followed by a mobile team to address physical health and behavioral health needs. In addition, in Quarter 2 of 2020 ACLA executed a contract with a provider who began facilitating care coordination and providing PCP and specialist access in Orleans, Jefferson and St. Bernard parishes. This provider coordinates care for assigned enrollees and provides telehealth services as needed. ACLA

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
						intends to seek LDH approval as this provider will be used to augment access to specialists using the telemedicine option to meet network adequacy requirements.
7.9						
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan	Minimal This requirement is not addressed explicitly in the documentation provided. **Recommendation** The MCO should assess the network capacity to address the needs of individuals with dual diagnosis of behavioral health and developmental disabilities. **MCO Response** ACLA will revise the current language to specifically state "specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders" in several	Minimal	This requirement is partially addressed in "7.9.3.1 Par Providers with Certain Services." The MCE has provided evidence of providers contracted who can meet needs of individuals with dual diagnosis of behavioral health and developmental disabilities. However, the MCE has not provided evidence that "the plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population. " **Recommendation**	ACLA will initiate a survey in Quarter 4 of 2020 for BH providers to self-report their ability to work with members with BH and developmental disabilities. This will be updated to the provider profile and reflected in the provider directory.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			documents. ACLA has increased the provider types of Applied Behavioral Analysis services from 29 when the service was carved in to the plan in March 2018 to a current number of 54 providers. These services are designed for members with specialized needs of behavioral health and developmental disabilities include autism spectrum disorders		The MCE should assess the extent to which their in-state network is sufficient to meet the needs of individuals with a dual diagnosis of behavioral health and developmental disabilities.	

MCO Final Audit Tools

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

Marketing and Member Education

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**					
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The MCO shall also comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i):					
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: • Flesch – Kincaid; • Fry Readability Index; • PROSE The Readability Analyst (software developed by Educational Activities, Inc.); • Gunning FOG Index; • McLaughlin SMOG Index; or • Other computer generated readability indices accepted by LDH.	P/P for Written Member Materials Guidelines Sample written member materials	Full			
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Full			
12.9.3	LDH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.					
12.9.4	If a person making a testimonial or endorsement for a MCO has a	P/P for Written Member	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	financial interest in the company, such fact must be disclosed in the marketing materials.	Materials Guidelines P/P for Disclosure of Financial Interest				
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	P/P for Written Member Materials Guidelines P/P for Compliance with "Person First" Policy Sample written member materials including Member Handbook	Full			
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Not Applicable The MCO does not have a commercial plan operating in Louisiana.			
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	P/P for Written Member Materials Guidelines Sample written member materials	Full			
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Interpretation Services	Full			
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Full			
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Access to Alternative Forms of	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Communication				
12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.					
12.11	**Member Education – Required Materials and Services**					
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	P/P for Member Education P/P for Member Disenrollment P/P for Member Enrollment P/P for Member Re-enrollment	Full			
12.11.3						
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal	Full			
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Example of bullets/news letter	Full			
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Brochures and other examples of literature including EPSTD materials	Full			
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN	Full			
12.11.3.5	Materials focused on health promotion programs available to the	Member education	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	members;	materials				
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications	Full			
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications	Full			
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material	Full			
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Example Member education material	Full			
12.11.3.11	Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and	Notification P/P member education	Full			
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P member education	Full			
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.).	Member Handbook	Full			
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:					
12.12.1.2	Table of contents;	Member Handbook	Full			
12.12.1.3	A general description about how MCOs operate, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;	Member Handbook	Full			
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.12.1.5	Member's right to select and change PCPs within the MCO and how to do so;	Member Handbook	Full			
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook	Full			
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook	Full			
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and LDH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	Member Handbook	Full			
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook	Full			
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook	Full			
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;	Member Handbook	Full			
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook	Full			
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook	Full			
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with LDH;	Member Handbook	Full			
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Member Handbook	Full			
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook	Full			
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook	Full			
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: o The right to a hearing; o The method for obtaining a hearing; and o The rules that govern representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing a grievance or appeal; • The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: o Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and o The member may be required to pay the cost of services	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	furnished while the appeal is pending, if the final decision is adverse to the member. • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services must be provided.					
12.12.1.20	Advance Directives, set forth in 42 CFR §438. 10 (g)(2) (xii) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Member Handbook	Full			
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Member Handbook	Full			
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Member Handbook	Full			
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook	Full			
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook	Full			
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;	Member Handbook	Full			
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	Member Handbook	Full			
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Member Handbook	Full			
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	Member Handbook	Full			
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	Member Handbook	Full			
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to LDH and MCO toll-free numbers and website established for that purpose;	Member Handbook	Full			
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook	Full			
12.12.1.33	The date of the last revision;	Member Handbook	Full			
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.3 (i)]. Service utilization policies; and How to report alleged marketing violations to LDH utilizing the Marketing Complaint Form.	Member Handbook	Full			
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: • A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers;	Member handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; • Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and • Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.					
12.12.1.36	Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;	Member handbook	Full			
12.12.1.37	The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:	Member handbook	Full			
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;		Full			
12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;		Full			
12.12.1.37.3	Posts the information on their member website and advises the member in paper or electronic form that the information is available at the specified web address; or		Full			
12.12.1.37.4	Provides the information in any other method that can be reasonably expected to result in the member receiving the information.		Full			
12.12.1.38	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	Member notification	Full			
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook	Full			
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four	P/P for Provider Directory	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	(4) formats:	Provider Directory				
12.14.1.1	A hard copy directory, when requested, for members and potential members;	P/P for Provider Directory Provider Directory (hard copy)	Full			
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)	Substantial This requirement is partially addressed in the provider directory. The MCO does not yet have a machine readable online directory. <u>Recommendation:</u> It is recommended that the MCO work to make the online directory" machine readable". Post-onsite, the MCO stated that they are working to implement machine readability by creating a link to the JSON file (which is machine readable) within the Member component of the Website. <u>MCO Response:</u> ACLA is moving ahead with ensuring that the provider directory within the Member section of the website is machine readable. While we do not have an exact timeframe for	Full	This requirement is addressed in the screenshots ACLA provided and is also evidenced on their website. **<u>IPRO Final Findings</u>** Based on ACLA response the determination was changed to Full.	This was previously corrected as was evidenced by the submission of the policy and the screenshot showing that the provider has undergone cultural competency training. This has been implemented for all providers who participate in ACLA's network. For your review, we are resubmitting the policy and the screenshot.

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			implementation, we are moving forward as expeditiously as possible to make this happen.			
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	P/P for Provider Directory Provider Directory (electronic file format)	Full			
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	P/P for Provider Directory Provider Directory (abbreviated hard copy)	Full			
12.14.3	The hard copy directory for members shall be reprinted with updates at monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	P/P for Provider Directory	Full			
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:					
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial This requirement is partially addressed in the New Provider/Practitioner Load /Data Update-Change Policy. Incorporation of whether a provider has completed cultural competency training is not found in the online provider directory <u>Recommendation:</u>	Full	This requirement is addressed in the New Provider/Practitioner Load/Data Update-Change Policy, in the Assessing the Cultural Responsiveness of the Provider Network Policy, and by the screenshot that ACLA provided.	

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			The MCO should work to include whether a provider has completed cultural competency training in their provider directory. Post onsite, the MCO stated that they are working to load this information into FACETS, which captures information about providers. This will populate the online directory, which has this search functionality in the member portal, through the Advanced Search option. <u>MCO Response:</u> This information is already being captured. However, ACLA is working to have this it populated in the online directory.			
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Full			
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	P/P for Provider Directory Provider Directory (full	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		hard copy, website version, electronic file, abbreviated hard copy)				
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).	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Full			
12.17.15	**Members' Rights and Responsibilities**					
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.17.16	**Member Responsibilities**					
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the	P/P for Member Rights and Responsibilities Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.					
12.18	**Notice to Members of Provider Termination**					
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	P/P for Provider Termination P/P for notifying members of provider termination	Full			
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service	P/P for Provider Termination P/P for notifying members of provider termination	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.					
12.19	**Oral Interpretation and Written Translation Services**					
12.19.1	In accordance with 42 CFR §438.10(d) LDH shall provide on its website the prevalent non-English language spoken by enrollees in the state.					
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services	Full			
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.	P/P for Member Rights and Responsibilities	Full			

Provider Network Requirements

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.1	**General Provider Network Requirements**					
7.1.1	The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.					
7.1.2	The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.1.3	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Full			
7.1.4	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Substantial This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendations** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	Substantial	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendation** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	See Section 7.3.1 below.
7.1.5	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO	Network Provider Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	P/P for Provider Network				
7.1.7	The MCO's network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Provider Network P/P for Access and Availability	Full			
7.1.8	At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.	P/P for Provider Network P/P for Access and Availability	Full			
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually;	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts	Substantial This requirement is addressed in the Provider Culture and Ethnicity Policy and Procedure and "FAX BLAST Provider Cultural Competency Training." Missing from the documentation is the requirement in bullet point 1 about collecting member demographic data. **Recommendations** The MCO should collect, and document that they collect, demographic data so that the needs of the community can be met. MCO Response ACLA will add this requirement to the Provider Culture and Ethnicity Policy (#CPNM	Full	This requirement is addressed in Policy and Procedure CPNM 339.450.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.		339.450) to ensure and validate that the collection of this demographic data is occurring in order to meet the needs of the community.			
7.2						
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. LDH will monitor the MCO's compliance with these standards through regular reporting as shown in Provider Network Companion Guide. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:					
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	shall be arranged within forty-eight (48) hours of request;	Update/Manual Provider contracts ACLA Member Handbook				
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		ACLA Member Handbook				
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	number at all times.					
7.3						
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendations** See recommendations for individual requirements in section 7.3. MCO Response Please see all responses below that responsive to this element.	Substantial	This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendations** See recommendations for individual requirements in section 7.3.	See Section 7.3.1 below.
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .3 Travel distance for members living in rural parishes shall not exceed 30 miles; and .4 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 3. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve access to PCPs for their urban members. MCO Response	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. **Recommendation** The MCE should improve access to PCPs for their urban members.	ACLA's network is open to PCPs who request to join and those the Account Executives (AEs) actively recruit. The AEs are aware of the urban parishes that have gaps for PCPs who treat adults - (Cameron for 9 members, Plaquemines for 81 members and Terrebonne for 13 members) and are working to recruit in these areas. The AEs are aware of the urban parishes that have gaps for PCPs who treat pediatrics - (Cameron for 15 mbrs and Plaquemines for 94 mbrs) and are working to recruit in these

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.9% of members in urban areas have access to an Adult or Pediatric PCP within the 20 minute requirement. ACLA is open to adding PCPs as providers' request. ACLA is currently outreaching providers who have been exclusively signed up with one or two health plans to add them to the network.			areas. ACLA initiated a contract effective May 2020 with a provider who provides PCP access and/or care coordination with member's assigned PCP. ACLA has discussed expanding their services to include Plaquemines and perhaps Terrebonne. Provider is in agreement and negotiations are in progress. ACLA currently has an initiative to recruit providers who have historically only accepted Medicare or commercial payors. This involves a tiered approach with an introductory letter with an attached contract template and PNM Director's contact information. The AE will follow up with a phone call within 30 days. An introductory meeting is offered to allow the provider to ask questions and concerns about the reimbursement rates. This is also an opportunity for the provider to propose any alternate payment models such as bundled or shared savings plans. In addition, the AEs

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
						continue to outreach par PCPs and large groups to expand services or open panels that may be closed due to meeting capacity. The AEs are educating the providers regarding alternate payment models to encourage par providers to keep panels open and to recruit new providers. Account Executives have been provided with a copy of the Report 220 and this analysis. They are reviewing a monthly Network Adequacy report and targeting provider outreach in the areas of need.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. <u>MCO Response</u> The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. ACLA is contracted with all acute hospitals in Louisiana. The state is considering whether it is appropriate to modify its contract requirements.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.1% of the members in urban parishes have access to an acute hospital within the 20 minute requirement. ACLA is contracted with all acute inpatient hospitals at this time. See the attached PH Network Development Service document in the row above.			
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed the Provider Network Companion Guide.. LDH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 5. A review of geo access reports indicates that time or distance requirements are not met for all parishes in most specialties. **Recommendations** The MCO should improve member access for most specialties. MCO Response Specialty types with gaps	Full	This requirement is addressed in 220 ACLA 2019 SA2. Distance requirements are met.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			include Allergy/Immunology, Dermatology, Endocrinology, Hematology, and Nephrology. Two (2) parishes in Region 7 have gaps for 3 of these specialty types and four parishes in Region 5 have gaps for Endocrinology. Region 6 has the largest gap for four of the specialty types noted above with the exception of Nephrology. Region 8 has gaps for the four specialty types noted above. ACLA is currently outreaching providers who historically only contracted with one or 2 of the MCO(s) to add them to the network which will add PCPs and specialty providers.			
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance and/or time requirements are not met for urban lab and urban radiology parishes (Plaquemines). **Recommendations** The MCE should improve member access to lab and radiology services in urban parishes.	There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA meets all access requirements when these access points are considered. Note that labs in these settings do not have unique NPI or tax ID numbers in order to be captured separate from the group type for reporting purposes.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			member access to lab and radiology services in urban parishes. The MCO has indicated that the Geo Access Report only includes stand-alone lab and radiology services and that more lab and radiology services are provided to members that are not counted in the geo access report. <u>MCO Response</u> There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA is also contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician office which increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing.			ACLA is contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician office which increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing. Quest and LabCorps are the two largest and they cover the entire state by using courier services for pick up at physician offices. When all draw sites for these two labs alone are considered, 100% of members in urban and rural parishes have access within the required standards.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .4 Travel distance shall not exceed 10 miles in urban parishes; and .5 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4.	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance requirement are not met for urban	PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provide access to retail and specialty pharmacy providers.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Requests for exceptions	A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **<u>Recommendations</u>** The MCO should improve member access to pharmacies in urban parishes. <u>MCO Response</u> ACLA is currently contracted with 1,182 pharmacy locations in Louisiana. Per NCPDP, there are currently nine pharmacies in the parishes with gaps (three in Plaquemines and six in Union). ACLA is contracted with all nine. ACLA is contracted with 71 pharmacies in Region 5 and 213 in Region 1. Only 0.1% of the enrollees in urban parishes do not have access within 20 minutes. Enrollees in all urban parishes, with the exception of Cameron and Plaquemines, have a drive time within 20 minutes to a pharmacy. AmeriHealth Caritas' PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provides		pharmacy parishes. **<u>Recommendation</u>** The MCE should improve member access to pharmacies in urban parishes.	There are currently only three pharmacies which operate in Plaquemines Parish which has the largest gap and ACLA is contracted with all three. Cameron Parish in Region 5 has a gap; however, there are no pharmacies in this parish for ACLA to contract with. ACLA is contracted with 71 pharmacies in Region 5. Therefore, there are no additional pharmacies with whom ACLA can add to the network. Consideration may include a joint effort with LDH and the other MCO(s) to address the needs and discuss solutions.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			access to retail and specialty pharmacy providers.			
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .2 Travel distance shall not exceed 10 miles in urban areas; and .3 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Minimal This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for some rural parishes and most urban parishes. **Recommendations** The MCO should improve member access to hemodialysis centers in rural parishes and especially in urban parishes. MCO Response Only 1.8% of the enrollees in urban parishes drive more than 20 minutes to this provider type. Among nine urban parishes in Regions 1, 2, 3, 5, 6, and 7, more than 90% of the enrollees have access within the required driving time. These include Bossier, Caddo, Calcasieu, De Soto, Pointe Coupee, Rapides, St. Bernard, Terrebonne and West Feliciana. The largest percentage of enrollees who	Substantial	This requirement is addressed in 220 ACLA 2019 SA2. Distance requirements are not met for urban parishes. **Recommendation** The MCE should improve member access to hemodialysis centers in urban parishes.	ACLA will determine if there are any dialysis providers in La. who are not currently contracted and attempt to recruit these providers into the network. This will be an initiative to start in Quarter 4 of 2020. Introductory meetings will be offered with these providers to discuss any options of interest that the provider may have or concerns. This is an opportunity for the provider to agree to the Medicaid rates or discuss alternate rates that would allow them to join the ACLA network.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			drive more than the maximum standard reside in Cameron (Region 5), Grant (Region 6), Lafourche (Region 3), Plaquemines (Region 1), and Union (Region 8) parishes. ACLA is working with providers to expand this level of care. There are 178 providers to date. Two new centers were added to ACLA's network in Quarter 2 2019 in Regions 1 and 6. ACLA continues to work with large providers, i.e. Fresenius, to increase access to these centers.			
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial A review of geo access reports indicates that time or distance requirements were not met for urban parishes. **<u>Recommendations</u>** The MCO should improve member access to specialized behavioral health providers in urban parishes.	Full	This requirement is addressed in BH Network Gap Analysis-2020 Q1 Distance and/or time requirements are met for rural and urban parishes.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response One hundred percent (100%) of enrollees in rural parishes have access to a BHS within 60 minutes, whereas 99.8 % of enrollees in urban parishes have access within the standard of 30 minutes. In Plaquemines Parish, 35% of the enrollees need to travel slightly more than the 30 minute standard. ACLA welcomes individual SBHS providers into the network and works with these providers to retain them.			
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes.	Substantial	This requirement is addressed in BH Network Gap Analysis-2020 Q1. Distance and/or time requirements are not met for urban and rural parishes. **Recommendation** The MCE should improve	ACLA will run the list of SU Residential providers from the La. Health Standards Section and target the non-par providers for recruitment during Q4 2020. Three AEs will be assigned to outreach targeted providers. Meetings will be offered to address providers' questions, concerns and payment structure

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Missing from the documentation provided are admissions data. **<u>Recommendations</u>** The MCO should improve member access to ASAM level 3.3. The MCO should record and report admission or appointment times for ASAM level 3.3 **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times. <u>MCO Response</u> Statutory report 359, Measurement 2 addressed the minimum performance thresholds for time of admission or appointment but this was never required and discontinued July 2018. ACLA continues to encourage these provider types to enter		member access to ASAM level 3.3.	requests since many of these currently only accept private or commercial pay.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			the ACLA network. ACLA has reached an agreement with Acadia Healthcare for ASAM Residential for adults and adolescents. ACLA completed contracting and credentialing for a new entity Substance Use Residential program and for existing sites with Addiction Recovery Resources which involved a change of ownership for 3 sites in Metairie and one site in Destrehan, La. These are referenced as Avenues Recovery. ACLA is also working on contracting with a Substance Residential Provider who has historically only accepted commercial pay in the New Orleans area. ACLA completed a project involving outreach to all network Substance Use providers to verify ASAM levels as these provider types added capacity and/or locations without notifying ACLA. Work requests to add or change ASAM levels is in progress. One provider in Ruston became credentialed adding SU Residential services. ACLA is contracted with all Opioid Treatment Program providers			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			with the exception of Choices who has not yet submitted a packet. See BH report above.			
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **<u>Recommendations</u>** The MCO should improve member access to ASAM level 3.5. The MCO should also record and report admission or appointment times for ASAM level 3.5. **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report	Substantial	This requirement is addressed in BH Network Gap Analysis-2020 Q1. Distance and/or time requirements are not met for urban and rural parishes. **<u>Recommendation</u>** The MCE should improve member access to ASAM level 3.5.	ACLA will run the list of SU Residential providers from the La. Health Standards Section and target the non-par providers for recruitment during Q4 2020. Three AEs will be assigned to outreach target providers. Meetings will be offered to address providers' questions, concerns and payment structure requests since many of these currently only accept private or commercial pay.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			admission or appointment times. <u>MCO Response</u> Same feedback as above.			
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **<u>Recommendations</u>** The MCO should improve member access to ASAM level 3.7 co-occurring treatment. The MCO should record and report admission or appointment times for ASAM level 3.7 co-occurring treatment. **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met	Full	This requirement is addressed in BH Network Gap Analysis-2020 Q1. Distance and/or time requirements are met for urban and rural parishes.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			LDH has confirmed that MCOs were not required to report admission or appointment times. <u>MCO Response</u> Same as above.			
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.10	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	P/P Access standards ACLA Member Handbook	Full			
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a	Network Provider Development and	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	Management Plan P/P for Access and Availability Evidence of meeting provider to member ratios				
7.5						
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Network Provider Development and Management Plan Provider contracts Provider manual/handbook P/P for Access and Availability P/P for Monitoring Provider Compliance with Access Standards Plan website Evidence that monitoring was implemented	Full			
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed the Provider Network Companion Guide. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider registry data submitted to LDH by the plans as required in the **MCO Systems Companion Guide.** The MCO report on accessibility shall include assessment	GeoAccess reports Communication to LDH/ attestation	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.					
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** • Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.	GeoAccess reports Communications to LDH	Minimal This requirement is addressed in the 348 BH and 220 PH Geo Access Reports. Missing from the reports are provider-to-member ratios. **<u>Recommendations</u>** The MCO should include provider-to-member ratios in the Geo Access Reports. **<u>Final Review Determination:</u>** No change in determination. We cannot accept new documents at this stage and the attached document is outside the review period (April 1, 2018 – March 31, 2019). <u>MCO Response</u> The Provider Network Companion Guide has the provider-to-member ratios for 12 specialty types, i.e. Allergy/Immunology is 1:100,000. The BH and PH GeoAccess reports include the number of members located in each parish. The number of	Full	This requirement is addressed in 348 BH and 220 ACLA 2019 SA2.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			providers for each provider type is noted on the actual maps. The total number of members divided by the number of that specialty type provides the ratio. The ratios have been analyzed on an annual basis. Based on current reporting templates developed by LDH, the provider-to-member ratio is required quarterly for each parish and this was analyzed in Quarter 2 of 2019.			
7.6	**Provider Enrollment**					
7.6.1	**Provider Participation -**					
7.6.1.6	The MCO must offer a Contract to the following providers: • Louisiana Office of Public Health (OPH); • all OPH-certified School Based Health Clinics (SBHCs); • all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs); • Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities;	Network Provider Development and Management Plan P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Methadone Clinics pending CMS approval; Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).					
7.6.1.7	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.6.1.8	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.6.1.9	The provisions above do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the	Network Provider Development and Management Plan P/P for Provider Network	Full		.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].					
7.6.1.10	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention Evidence of timely notice of denied provider requests for participation Sample notice to providers	Full			
7.6.1.11	The MCO shall work with LDH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	P/P care coordination Meeting/Forum Meetings	Full			
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Credentialing P/P for Provider Selection and Retention	Full			
7.6.2.2 7.6.2.2.1 7.6.2.2.2	The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to	P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.6.2.2.3 7.6.2.2.4 7.6.2.2.5 7.6.2.2.6	Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings: .1 Revocation of the provider's home and community-based services license or behavioral health service license; .2 Exclusion from the Medicaid program; .3 Termination from the Medicaid program; .4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41); .5 Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.					
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	P/P for Provider Network	Full			
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)] The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2).In addition, the MCO must not discriminate against particular providers	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention P/P for Provider Credentialing	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].					
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook P/P for Provider Credentialing	Full			
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	P/P for Provider Network P/P for Provider Termination Sample notice to providers Sample notice to LDH	Full			
7.6.3.5	If termination affects network adequacy, the MCO shall include in the notification to LDH their plans to notify MCO members of such change and strategy to ensure timely access for MCO members through different in-network and/or out-of network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure there will be no stoppage or interruption of services to members.	P/P for Provider Network P/P for Provider Termination Sample notice to members	Full			
7.6.3.6	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	P/P for Provider Network P/P for Provider Termination Sample notice to members ACLA Member Handbook	Full			
7.15.1	The MCO must designate a credentialing committee that uses a peer review process to evaluate provider	P/P for credentialing committee.	New Requirement	Full	This requirement is addressed in 7.15.1 CP	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files. A physician must oversee the credentialing committee.	P/P for credentialing decisions Credentialing committee minutes			210.104 and credentialing committee minutes.	
7.7	**Mainstreaming**					
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Provider contracts/Manual	Full			
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider contracts/Manual Member Handbook	Full			
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts/Manual	Full			
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Provider contracts/Manual	Full			
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Provider contracts/Manual	Full			
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming,	Provider contracts/Manual	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify LDH in writing					
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Provider contracts/Manual	Substantial This requirement is addressed in the ACLA Specialty Care Provider Agreement on page 15. Missing from the documentation provided is explicit mention that the MCO shall ensure that providers do not exclude treatment for behavioral health services solely on the basis of state agency involvement. **Recommendations** The MCO should include in the policy the requirement that the MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral. MCO Response ACLA is adding the statement that “ACLA shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely	Full	This requirement is addressed in the Provider Handbook on page 26.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			on the basis of state agency (DCFS or OJJ, etc.) involvement or referral" to the Provider Manual.			
7.8.2	**Primary Care Provider Responsibilities**					
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:					
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	P/P for PCP responsibilities Provider contracts/Manual	Full			
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	P/P for PCP responsibilities Provider contracts/Manual	Full			
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.8	Providing after-hours availability to patients who need	P/P for PCP Responsibilities	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	Provider contracts/Manual				
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	P/P for PCP Responsibilities Provider contracts/Manual	Full			
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.					
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports	Full			
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports	Full			
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to	P/P for Provider Network P/P for Access to Specialty Providers	Substantial This requirement is addressed in section 7.3, Geographic Access	Substantial	This requirement is addressed in section 7.3, Geographic Access	ACLA will continue to work with our existing provider systems to gain greater

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	GeoAccess reports Evidence of signed contracts with listed specialty provider types	Requirements. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. **Recommendations** The MCO should improve member access to urban and rural parishes. MCO Response See above response.		Requirements. A review of geographic access reports indicates that time and/or distance requirements are not met for all urban and rural parishes. **Recommendation** The MCE should improve member access to urban and rural parishes.	access of specialists in parishes where gaps exist and collaborate with healthcare systems to increase access in Vernon and Beauregard parishes. ACLA has initiated an updated recruitment process to include provider letters, flier and a brief presentation. Currently, the team is working on requested alternate payment models (APM) for potential providers who will only consider enhanced rates with an APM option. ACLA will focus on adding specialists in Plaquemines Parish by working to add telemedicine and expanding new programs that were implemented in 2019, such as Ready Responders. Ready Responders is a treat-in-place program whereas members can be seen in the community including their home when their PCP is not available impromptu. This program offers medical triage followed by a mobile team to address physical

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
						health and behavioral health needs. In addition, in Quarter 2 of 2020 ACLA executed a contract with a provider who began facilitating care coordination and providing PCP and specialist access in Orleans, Jefferson and St. Bernard parishes. This provider coordinates care for assigned enrollees and provides telehealth services as needed. ACLA intends to seek LDH approval as this provider will be used to augment access to specialists using the telemedicine option to meet network adequacy requirements.
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements set in this Section and in the Provider Network Companion Guide.					
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by LDH the MCO does not meet the access standards specified in the Contract.	P/P for Provider Network P/P for Access to Specialty Providers	Not applicable LDH has not required a change to ratio requirements.			
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to	P/P for Provider Network P/P for Access to Specialty Providers	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	P/P for direct access services				
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.					
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: .1 One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. .2 MCO must establish access to the following within their network of hospitals: • Level III Obstetrical services; • Level III Neonatal Intensive Care (NICU) services; • Pediatric services; • Trauma services; • Burn services; and • A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.	P/P for Provider Network GeoAccess reports	Full			
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	P/P for Provider Network GeoAccess reports	Full			
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	P/P for Provider Network GeoAccess reports	Full			
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide	P/P for use of out-of-network providers P/P for providing access to tertiary care GeoAccess reports	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.					
7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	P/P for direct access services	Full			
7.8.6.1	The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.	P/P for direct access services	Full			
7.8.6.2	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.	P/P for direct access services ACLA Member Handbook	Full			
7.8.6.3	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR	P/P for direct access services ACLA Member Handbook	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	§431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.					
7.8.6.5	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	P/P for Direct Access Services	Full			
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	P/P for Prenatal Care Services Access P/P for Assignment of PCPs including Auto Assignment	Full			
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Evidence of availability of other medical service providers	Full			
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	P/P for Provider Network Contracts with FQHC/RHCs	Full			
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the LDH Office of Public Health) services					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.					
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	P/P for Provider Network Contracts with SBHCs	Full			
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STI, family planning).	P/P for Provider Network Contract with Louisiana OPH	Full			
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	P/P for Provider Network Contract with Louisiana OPH	Full			
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.2	The MCO shall ensure its provider network offers a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. The provider network shall be adequate for the anticipated number of members for the service area. The					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	service array shall comply with the waivers and Medicaid State Plan requirements.					
7.8.14.3	The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.		Full			
7.8.14.4	The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.		Full			
7.8.14.5	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.7	The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services	P/P provider network P/P care coordination Network reports	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	during evenings and weekends.					
7.8.14.8	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, warm line, crisis counseling crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, mobile crisis teams, and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. If shortages in provider network sufficiency are identified by LDH, the MCO shall conduct outreach efforts approved by LDH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.10	The MCO shall require behavioral health providers to screen for basic medical issues.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.11	The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.12	The MCO shall report the number of out-of-state	P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	P/P care coordination				
7.8.15 7.8.15.1	**Indian Health Care providers (IHCPs)** The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.	P/P provider network P/P care coordination Network reports	Full			
7.8.15.2 7.8.15.2.1 7.8.15.2.2 7.8.15.2.3	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows: • At a rate negotiated between the MCO and the IHCP; or • In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and • Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.		Full			
7.8.15.4	The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.		Full			
7.8.15.5 7.8.15.5.1	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be	P/P provider network P/P care coordination	Substantial This requirement is addressed in	Full	This requirement is addressed in 159.201	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.8.15.5.2	considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .1 Indian members are permitted by the MCO to access out-of-state IHCPs; or .2 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	Network reports	the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 5. Missing from the provided documents is an indication of whether members are permitted by ACLA to access out-of-state IHCPs or if this circumstance is deemed to be good cause for disenrollment. **Recommendations** The MCO should address in policy whether: "Indian members are permitted by the MCO to access out-of-state IHCPs; or If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c)." MCO Response ACLA will add this to the Provider Accessibility and Availability Standards and Compliance Policy (#159.201). Also, ACLA has a clinical liaison who completes single case agreements for members who need care and/or treatment out of the state.		Provider Accessibility Standards and Compliance Policy on page 6.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.8.15.6	The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.	P/P provider network P/P care coordination Network reports	Full			
7.9						
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to LDH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.68):	Provider Network Development and Management Plan	Full			
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan	Full			
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan	Full			
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Provider Network Development and Management Plan	Full			
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan	Full			
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid	Provider Network Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	enrollees with disabilities.					
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Provider Network Development and Management Plan	Full			
7.9.2.1	Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)	Provider Network Development and Management Plan	Full			
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members in the service area;	Provider Network Development and Management Plan	Full			
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan	Full			
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan	Full			
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan	Full			
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan	Full			
7.9.2.7	Timely Access	Provider Network Development and Management Plan	Full			
7.9.2.8	Service Area	Provider Network Development and Management Plan	Full			
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health ,	Provider Network Development and	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Special Conditions for Prenatal Providers, • Second Opinion • Out-of-Network Providers	Management Plan				
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.	Provider Network Development and Management Plan	Full			
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan	Minimal This requirement was not addressed explicitly in the documentation provided. **<u>Recommendations</u>** The MCO should assess the network capacity to address the needs of individuals with dual diagnosis of behavioral health and developmental disabilities. <u>MCO Response</u> ACLA will revise the current language to specifically state "specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders" in several documents. ACLA has increased the provider types of Applied Behavioral	Minimal	This requirement is partially addressed in "7.9.3.1 Par Providers with Certain Services." The MCE has provided evidence of providers contracted who can meet needs of individuals with dual diagnosis of behavioral health and developmental disabilities. However the MCE has not provided evidence that "the plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population. **Recommendation**	ACLA will initiate a survey in Quarter 4 of 2020 for BH providers to self-report their ability to work with members with BH and developmental disabilities. This will be updated to the provider profile and reflected in the provider directory.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Analysis services from 29 when the service was carved in to the plan in March 2018 to a current number of 54 providers. These services are designed for members with specialized needs of behavioral health and developmental disabilities include autism spectrum disorders		The MCE should assess the extent to which their in-state network is sufficient to meet the needs of individuals with a dual diagnosis of behavioral health and developmental disabilities.	
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory	Minimal This requirement was not addressed explicitly in the documentation provided. **<u>Recommendations</u>** The MCO should clearly identify whether a provider is specialized in serving individuals with a dual diagnosis of behavioral health and developmental disabilities. <u>MCO Response</u> In addition to the above statement, ACLA will work to add specifications to clearly identify this in the provider directory.	Full	This requirement is address in the Network Development Plan on pages 29 and 31 and in screen shots of the provider directory.	
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to LDH quarterly, or upon material change (as defined in the Glossary) or upon request.	Provider Network Development and Management Plan GeoAccess reports	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	P/P for Network Development and Management	Full			
7.9.5.2	Monitor network compliance with policies and rules of LDH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	P/P for Network Development and Management	Full			
7.9.5.3	Evaluate the quality of services delivered by the network;	P/P for Network Development and Management	Full			
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	P/P for Network Development and Management	Full			
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	P/P for Network Development and Management	Full			
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	P/P for Network Development and Management	Full			
7.9.5.7	Provide training for its providers and maintain records of such training;	P/P for Network Development and Management	Full			
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	P/P for Network Development and Management	Full			
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result	P/P for Network Development and	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	communicated to the provider within 30 business days of receipt (this includes referrals from LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Management				
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to LDH at the end of the first year of operations and annually thereafter.	P/P for Evaluation of Network Provider Development and Management Plan	Full			
7.9.7	MCO Network Development and Management policies shall be subject to approval by LDH, Medicaid Managed Care Section and shall be monitored through operational audits.	Evidence of submission of P/P for Network Development and Management to LDH	Full			
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to LDH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Network development Implementation plan P/P provider network	Full			
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Network development Implementation plan P/P provider network	Full			
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to	Network development Implementation plan P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	perform activities associated with this contract;					
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network development Implementation plan P/P provider network	Full			
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to LDH quarterly by contract year, upon material change of the network, or upon request;	Network development Implementation plan P/P provider network	Full			
	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include: • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services; • Specialized behavioral health service needs of members; and • Growth trends in eligibility and enrollment, including: o Current and anticipated numbers of Title XIX and Title XXI eligibles; and o Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.	P/P network Needs assessment findings	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Accessibility of services, including: o The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; o The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; o Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.	Network development Implementation plan P/P provider network	Full			
7.9.8.3	The MCO shall submit to LDH as part of its annual Network Development and Management Plan, and upon request of LDH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need;	Evidence of submission of network development Plan to LDH Network Development Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Provider grievance, appeal and request for arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.					
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.	Network development and management plan	Full			
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as:	Network development and management plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.					
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on	Network development and management plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network development and management plan	Full			
7.11						
7.11.1	The MCO shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than five percent	Evidence of communications with LDH P/P provider contracting	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	(5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.					
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in value-added benefits and services, payments, or eligibility of a new population.	Evidence of communication with LDH P/P Provider network	Full			
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Request for approval communications Notification to Member	Full			
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Request for approval	Full			
7.11.5	If LDH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, LDH will expedite the approval process.					
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid Managed	Notification to LDH	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	P/P provider network				
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Provider contracts P/P provider contracting	Full			
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: .1 Provide written notice to LDH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area	Evidence of notifications P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	where another provider of equal service ability is not available as required by access standards approved by LDH.					
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	P/P provider network	Full			
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. .1 The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.	Request for approval letter	Full			
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to LDH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to	Written plan P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	appropriate alternative behavioral health service providers in accordance with the network notification requirements.					
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Tracking report P/P service coordination	Full			
7.12						
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	P/P for Coordination with Other Service Providers	Full			
7.13						
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P/P for Network Management P/P for Provider Selection and Retention	Full			
7.14						
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs	P/P for credentialing & recredentialing	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.					
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation	P/P provider contracting	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Facilities (CARF); or • The Joint Commission (TJC).					
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review	Full			
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review	Full			
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.	P/P for credentialing & recredentialing	Full			
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	P/P for credentialing & recredentialing P/P for subcontractor delegation and requirements Credentialing subcontractor contract Includes Credentialing/Recredentialing File Review	Full			
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	P/P for credentialing & recredentialing	Full			
7.14.5.2	Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or	P/P for credentialing & recredentialing Provider Directory Evidence of submission of	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		the Provider Directory				
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	P/P for credentialing & recredentialing	Full			
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.	P/P for credentialing & recredentialing Delegation Contracts	Full			
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	P/P for credentialing & recredentialing	Minimal This requirement is addressed in the Credentialing /Re-credentialing of Practitioners. Missing from the supplied documents is the requirement that the MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance. **<u>Recommendation</u>** The MCO should indicate in the policy that they will not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance. <u>MCO Response</u> ACLA does not have any specialized behavioral health providers delegated at this time. However, ACLA will add this to	Full	This requirement is addressed in 7.14.7 CP 210 107.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			the Credentialing and Recredentialing of Practitioners Policy (#CP 210.104).			
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	P/P for credentialing & recredentialing	Full			
7.14.9	The MCO shall notify LDH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	P/P for credentialing & recredentialing	Full			
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	P/P for credentialing & recredentialing	Full			
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	P/P for credentialing & recredentialing	Full			
7.14.12	The MCO shall develop and implement a mechanism, subject to LDH 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.	P/P for credentialing & recredentialing P/P for reporting provider quality deficiencies Documented process for reporting quality deficiencies resulting in suspension or termination	Full			
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions,	P/P for credentialing & recredentialing	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	P/P for provider dispute and appeal process Documented provider dispute and resolution process for sanctions, suspensions and terminations Evidence of timely process submission				
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.					
7.16						
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts	Full			
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts	Full			
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Provider contracts				
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts	Full			
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts	Full			
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.					
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook	Full			

Quality Management

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**					
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.330(a)(1), to:					
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QAPI Program Description QAPI Work Plan	Full			
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QAPI Program Description QAPI Work Plan	Full			
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan	Full			
14.1.6	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by LDH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	QAPI Program Description QAPI Work Plan	Full			
14.1.7	The MCO shall reduce underutilization of services in areas including, but not limited to	QAPI Program Description	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	QAPI Work Plan				
14.1.8	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	QAPI Program Description QAPI Work Plan	Full			
14.1.9	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Program Description QAPI Work Plan	Full			
14.1.10	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QAPI Program Description QAPI Work Plan	Full			
14.1.11	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of LDH.	QAPI Program Description QAPI Work Plan	Full			
14.1.12	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and	QAPI Program Description QAPI Work Plan	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.					
14.1.13	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.	QAPI Program Description QAPI Work Plan	Full			
14.1.15	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	QAPI Program Description QAPI Work Plan	Full			
14.1.16	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Feedback reports QAPI work plan	Full			
14.1.17	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH.	Evidence of submission to LDH	Full			
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Clinical guidelines for ADHD Provider education Provider manual	Full			
14.1.19	The MCO shall conduct peer review to evaluate	P/P provider	Full			

Quality Management						
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	the clinical competence and quality and appropriateness of care/services provided to members.	oversight Peer review reports				
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets	Full			
14.1.21	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH	Full			
14.1.21.1 14.1.21.2	.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. .2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to LDH-OBH on an annual base.	Outcome measures and results BH outcome measures and evidence shared with LDH	Full			
14.2	**QAPI Committee**					
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:					
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Description Composition of QAPI Committee				
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.5	The MCO shall include LDH representative(s) on the QAPI Committee, as designated by LDH as non-voting member(s).	QAPI Program Description Composition of QAPI Committee	Full			
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Program Description QAPI Work Plan QAPI Committee Description including roles and responsibilities	Full			
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description	Full			
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description	Full			
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description	Full			
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QAPI Program Description	Full			
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description	Full			
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description	Full			
14.2.2.7	Report findings to appropriate executive	QAPI Program	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	authority, staff, and departments within the MCO;	Description				
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description	Full			
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to LDH;	QAPI Program Description	Full			
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management services;	QAPI Program Description	Full			
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description	Full			
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Program Description	Full			
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 LDH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	QAPI Program Description QAPI Work Plan Evidence of timely submission of the written QAPI plan	Full			
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QAPI Program Description	Full			
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description	Full			
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	QAPI Program Description	Full			
14.2.3.4	Describe the role of its providers in giving input	QAPI Program	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	to the QAPI Program; and	Description				
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QAPI Program Description	Full			
14.2.3.6	Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	QAPI program description	Full			
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	Monitoring plan	Full			
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to LDH which, at a minimum, shall include: • Quality improvement (QI) activities; • Recommended new and/or improved QI activities; and • Results of the evaluation of the impact and effectiveness of the QAPI program.	QAPI Program Description	Full			
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to LDH using the specifications and format approved by LDH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and LDH.	QAPI Program Description	Full			
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report on performance measures listed in Attachment E and in accordance with the timeline and format specified in the MCO Quality Companion	HEDIS IDSS results PM results	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Guide.					
14.2.5.2	The MCO shall have processes in place to monitor and self-report all performance measures.	P/P performance measures Final audit report	Full			
14.2.5.3	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	P/P performance measurement	Full			
14.2.5.4	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	P/P QAPI program description	Full			
14.2.5.5	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.	P/P QAPI program description	Full			
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan	Full			
14.2.5.7 14.2.5.7.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Attachment E annotated with "$$".	HEDIS results – incentive measures	Full			
14.2.5.7.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below LDH's established benchmarks for improvement.					
14.2.5.7.3	LDH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and LDH will provide six (6) months' notice of such change.	P/P Performance measures	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.2.5.8 14.2.5.8.1	**Performance Measures Reporting** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	HEDIS results IDSS submission Final audit report				
14.2.5.8.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by LDH.		Full			
14.2.5.8.3	The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.2.5 Performance Measures.	P/P performance measures	Full			
14.2.5.9	Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	P/P performance measures	Full			
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.330.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. LDH may require up to two (2) additional projects for a maximum of four (4) projects.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional LDH-approved behavioral-health PIP each contract year.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.3	Performance Improvement Projects shall be	PIP	Full			

Quality Management						
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	designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective quality indicators; • Implementation of interventions to achieve improvement in the access to and quality of care; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	proposal/reports P/P performance input projects PIP meeting minutes				
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to LDH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO members and providers; • The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly;	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.					
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.					
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	CAHPS report	Full			
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	CAHPS Vendor contract	Full			
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS report	Full			
14.2.10.5	The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses will be aggregated by	CAHPS data file	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.					
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used	Full			
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS reports	Full			
14.2.10.8 14.2.10.8.1 14.2.10.8.2 14.2.10.8.3 14.2.10.8.4 14.2.10.8.5	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: .1 Getting Needed Care, .2 Getting Care Quickly, .3 How Well Doctors Communicate, .4 Health Plan Customer Service, .5 Global Ratings.	CAHPS reports	Full			
14.2.10.9	The MCO's vendor shall perform a LDH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to LDH on an annual basis.	P/P Behavioral health survey Timeline for BH survey administration BH survey results, if administered	Full			
14.4	**Health Plan Accreditation**					
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide LDH with a copy of all correspondence with NCQA	Accreditation Status including copy of accreditation	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	regarding the application process and the accreditation requirements.	report if accredited				
14.4.3	The MCO shall provide LDH with a copy of its most recent accreditation review including:	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.1	Accreditation status, survey type, and level (as applicable);	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.2	Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	Accreditation Status including copy of accreditation report if accredited	Full			
14.5	**Member Advisory Council**					
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus	Member Advisory Council Plan Member Advisory Council	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and allow participation in providing input on policy and programs.	Composition Member Advisory Council Description including roles and responsibilities				
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council	Full			
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Member Advisory Council Plan Member Advisory Council Composition	Full			
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Member Advisory Council Plan	Full			
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan	Full			
14.5.6.	LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council	Member Advisory Council Plan	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.					
14.6 14.6.1	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.	Fidelity monitoring plan MOUs Evidence of submission to LDH	Full			
14.6.2	The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH specified ACT Monitoring tool. The MCO shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.	Fidelity monitoring plan Evidence of submission to LDH	Full			
14.6.3	A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling	Fidelity monitoring plan Site visit reports Evidence of submission to LDH	Full			

Quality Management						
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	approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by LDH. Reports will be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.					
14.8 14.8.1	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by LDH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.	P/P BH reporting Critical incident reporting system	Full			
14.8.2	The MCO, as directed by LDH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.					
14.8.3	The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	P/P BH reporting	Full			

Quality Management						
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14.9	**Provider Monitoring Plan and Reporting**					
14.9.1	The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:	P/P BH reporting Evidence of report submission to LDH	Full			
14.9.1.1	Review criteria for each applicable provider type/level of care;		Full			
14.9.1.2	Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;		Full			
14.9.1.3	Member interview criteria;		Full			
14.9.1.4	Random audit selection criteria;		Full			
14.9.1.5	Tools to be used;		Full			
14.9.1.6	Frequency of review, including schedule of reviews by provider type;		Full			
14.9.1.7	Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;		Full			
14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and		Full			
14.9.1.9	Inter-rater reliability testing methods.		Full			
14.9.2	At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one	P/P BH reporting	Full			

Quality Management						
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	member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient /residential. Additional levels of care may be added at the discretion of LDH.					
14.9.3	The MCO's review criteria shall address the following areas at a minimum:					
14.9.3.1	Adherence to clinical practice guidelines;		Full			
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;		Substantial Confidentiality is noted as a review element in the 356 Provider Monitoring Strategy on page 1 but is not an element in the review tool. <u>Recommendation:</u> ACLA should explicitly add maintenance of "member confidentiality" in the provider monitoring review tool, perhaps in the Member Rights section of the tool that covers release of information, page 8. <u>MCO Response:</u> ACLA has incorporated the maintenance of "member confidentiality to the review tool. See the document attached below. The template is being used effective 8/12/2019.	Full	This requirement is addressed in the Provider Monitoring Template Tool.	
14.9.3.3	Cultural competency;		Full			
14.9.3.4	Patient safety;		Full			

Quality Management						
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14.9.3.5	Compliance with adverse incident reporting requirements;		Full			
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;		Full			
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and		Full			
14.9.3.8	Continuity and coordination of care, including adequate discharge planning		Full			
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on					

Quality Management						
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	MCO measurement findings.					
14.9.5	The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.	Provider Monitoring P/P	Full			
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for Specialized Behavioral Health Services.	Provider Monitoring P/P Provider Monitoring Reports	Full			
14.10	**Outcome Assessment for Specialized Behavioral Health Services**					
14.10.1	The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.	BH outcome assessment plan Assessment Reports	Full			
14.10.2	The MCO shall ensure providers and appropriate MCO staff are adequately trained/ certified in the use of such tools and such training/certification is current.	BH outcome assessment plan Training materials Evidence of Training Attendance	Full			
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.	BH outcome assessment plan	Full			

Core Benefits and Services

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**					
6.4.5 6.4.5.1	**Permanent Supportive Housing** LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid Managed Care members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388 Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. For the Louisiana PSH program, the MCO shall:					
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member letters Member handbook P/P member education	Full			
6.4.5.1.2	Assist members in completing the PSH program application;	Member letters Member handbook	Full			

Core Benefits and Services						
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		P/P member education				
6.4.5.1.3	Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	Communications to LDH P/P education	Full			
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and	Completed LDH template	Full			
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:					
6.4.5.2.1	Identify a PSH program liaison, to be approved by LDH, to work with LDH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Organizational chart	Full			
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.	Training slides P/P provider education Provider handbook	Full			
6.4.9.1	The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider handbook Provider education materials Provider contracts P/P provider education	Full			

Core Benefits and Services						
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6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	P/P provider education Provider handbook	Full			
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	P/P behavioral integration Communications with community agencies	Full			
6.8	**Emergency Medical Services and Post Stabilization Services**					
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized	Member handbook P/P ER services	Full			

Core Benefits and Services						
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	behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.					
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member handbook	Full			
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Member handbook P/P Member services	Full			
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	Member handbook P/P emergency services	Full			
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	Provider handbook P/P Care coordination	Full			
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the	P/P Coordination of services Communications to hospital	Full			

Core Benefits and Services						
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	judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.					
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to LDH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	P/P Coordination of Services Quality of core plan Member handbook	Full			
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member & provider handbook Educational materials	Full			
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency 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	P./P Emergency services Member handbook	Full			

Core Benefits and Services						
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	possesses an average knowledge of health and medicine.					
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member handbook	Full			
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:					
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	P./P post stabilization services	Full			
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	P./P post stabilization services	Full			
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	P./P post stabilization services	Full			
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of	P./P post stabilization services Provider handbook	Full			

Core Benefits and Services						
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	the criteria of (422.133(c)(3)) is met.					
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	P./P post stabilization services				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	P./P post stabilization services	Full			
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	P./P post stabilization services	Full			
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	P./P post stabilization services	Full			
6.8.2.2.4	The member is discharged.	P./P post stabilization services	Full			
6.16	**Sterilization**					
6.16.2	Sterilization must be conducted in accordance with Louisiana R.S. 40:1159.2, state Medicaid policy, federal regulations contained in 42 CFR §441.250 - 441.259. All procedures must be documented with a completed Sterilization Consent Form OMB 0937-0166.	P/P Sterilization Services Member Handbook/website Provider Manual/portal	New Requirement	Substantial	This requirement is partially addressed in the Provider Handbook on pages 73-74, and in the Consent for Sterilization form; however, there is no sterilization policy document to support that sterilization is conducted in accordance with federal regulations 441.253 Sterilization of a mentally competent individual aged 21 or older and 441.254 Mentally incompetent or institutionalized individuals. In addition, the Member Handbook does not inform the member about this service. **Recommendation** The MCE should develop a sterilization policy that addresses these requirements, and to include corresponding benefit language in the Member Handbook. In follow-up,	ACLA Corrective Action Plan: To ensure that the sterilization policy and member handbook are updated to include that sterilization is conducted in accordance with federal regulations 441.253 and 441.254. These updates have been made. Attached for your review are the updated sterilization policy and member handbook information.

Core Benefits and Services						
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					the MCE provided a Sterilization Policy effective 9/2/20 that meets this requirement for the next compliance review year. The MCE also indicated that the Member Handbook will be updated.	
6.19	**Services for Special Populations**					
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:					
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;					
6.19.1.2	Individuals with intravenous drug use;					
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;					
6.19.1.4	Individuals with substance use disorders who have dependent children;					
6.19.1.5	Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;					
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II					

Core Benefits and Services						
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	determination;					
6.19.1.7	Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter or are transitioning out of the CSoC program.					
6.19.1.8	Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;					
6.19.1.9	Individuals with co-occurring behavioral health and developmental disabilities;					
6.19.1.10	Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;					
6.19.1.11	Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and					
6.19.1.12	Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.					
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of	HRA P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.					
6.19.3	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: .1 The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, LDH approved, guidelines for SHCN criteria. .2 MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. .3 Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. .4 Members may be identified by LDH and that information provided to the MCO.	P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review	Full			
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s)and a person-centered plan of	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case	Full			

Core Benefits and Services						
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	care developed by the MCO care manager. The individualized treatment plans must be:	Management File Review				
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Treatment plan P/P Individual Treatment Plans Documentation of communication Includes Case Management File Review	Full			
6.19.4.2	In compliance with applicable quality assurance and utilization management standards:	P/P Individual Treatment Plans				
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	P/P Individual Treatment Plans Plan of Care Includes Case Management File Review	Full			
6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.	P/P Individual Treatment Plans Plan of Care	Full			

Core Benefits and Services						
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6.28	**Care Management**					
6.28.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	CM records Member Handbook	Full			
6.28.2 6.28.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	P/P member Services Provider handbook Includes Care Management File Review	Full			
6.28.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	P/P member Services Call center documentation	Full			
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and	CM records P/P for care coordination Includes Care Management File Review	Full			

Core Benefits and Services						
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	coordination for members requiring behavioral health services.					
6.28.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	Pain management plans P/P for care coordination Includes Care Management File Review	Full			
6.30	**Care Coordination, Continuity of Care, and Care Transition**					
6.30.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to LDH by January 11, 2016. Continuity of care activities shall provide	P/P for care coordination P/P for PCP choice Member survey Detailed Workflows	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.					
6.30.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	P/P for care coordination	Full			
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
6.30.2.1	Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) day time period;	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.2	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	P/P for care coordination Includes Care	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Management File Review				
6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.4	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	P/P for care coordination	Full			
6.30.2.5	Coordinate care for out-of-network services, including specialty care services;	P/P for care coordination	Full			
6.30.2.6	Coordinate MCO provided services with services the member may receive from other health care providers;	P/P for care coordination	Full			
6.30.2.7	Upon request, share with LDH or 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;	P/P for care coordination	Full			
6.30.2.8	Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;	P/P for care coordination Provider Handbook	Full			
6.30.2.9	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	P/P for care coordination	Full			
6.30.2.10	Maintain and operate a formalized hospital and/or institutional discharge planning program;	P/P for care coordination Includes Care Management File Review	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.30.2.11	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.11.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	P/P for care coordination	Full			
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	P/P for care coordination CM records Includes Care Management File Review	Full			
6.30.2.11.3.	Coordination with LDH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	P/P for care coordination	Full			
6.30.2.11.4	Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care	P/P for care coordination Includes Care Management File Review	Full			

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.					
6.30.2.12	Document authorized referrals in its utilization management system;	P/P for care coordination	Full			
6.30.2.13	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less:	P/P for care coordination	Full			
6.30.2.14	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and	P/P care coordination Court proceedings	Full			
6.30.2.15	For the behavioral health population, provide aftercare planning for members	P/P care coordination	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	prior to discharge from a 24-hour facility.					
6.36	**Continuity for Behavioral Health Care**					
6.36.1	The PCP shall provide basic behavioral health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	P/P for BH care continuity Provider contract Provider manual/handbook	Full			
6.36.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable	P/P for BH care continuity	Full			

Core Benefits and Services						
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	standards of medical record confidentiality and the protection of patient privacy.					
6.36.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	P/P for BH care continuity Communication member	Full			
6.36.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	P/P for BH care continuity	Full			
6.36.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	P/P for BH care continuity	Full			
6.36.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	P/P for BH care continuity	Full			
6.36.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities	P/P for BH care continuity	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and agencies and require complex coordination of benefits and services.					
6.36.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	P/P for BH care continuity	Full			
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3 6.36.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.	P/P for BH care coordination	Full			
6.36.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	P/P provider contracting Provider contracts	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.36.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Provider portal/handbook Training materials	Full			
6.36.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	Member/provider handbook Educational materials	Full			
6.36.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	P/P coordination of care	Full			
6.36.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	P/P coordination of care	Full			
6.36.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Clinical management system records	Full			
6.36.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	P/P provider initiatives	Full			
6.36.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Training materials Provider handbook	Full			
6.36.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CM rounds minutes/schedule	Full			
6.36.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of	Meeting minutes	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	coordination and communication.					
6.40	**Case Management (CM) Policies and Procedures**					
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	P/P for CM	Full			
6.40.1	A process to offer voluntary participation in the Case Management Program to eligible members;	P/P for CM	Full			
6.40.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	P/P for CM	Full			
6.40.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.	P/P for CM	Full			
6.40.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe	P/P for CM Treatment plan template	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	collaboration processes with member's treatment providers;					
6.40.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	P/P for CM	Full			
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	P/P for CM	Full			
6.40.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	P/P for CM	Full			
6.40.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	P/P for CM	Full			
6.41	**Case Management Reporting Requirements**					
6.41	The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Evidence of Communication to LDH P/P CM	Full			
6.41.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	CM/Special health Care needs reports	Full			
6.41.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	CM/Special health Care needs reports	Full			
6.41.3	Number of members identified with potential special healthcare needs that self- refer;	CM/Special health Care needs reports	Full			
6.41.4	Number of members with potential special healthcare needs identified by the	CM/Special health Care needs reports	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	MCO;					
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports	Full			
6.41.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	CM/Special health Care needs reports	Full			
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports	Full			
6.41.8	Number of members with assessments resulting in a referral for Case Management.	CM/Special health Care needs reports	Full			
6.42	**Chronic Care Management Program (CCMP)**					
6.42.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	P/P for CCMP CCMP descriptions	Full			
6.42.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to LDH.	P/P for CCMP CCMP descriptions	Full			
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The	P/P for CCMP CCMP descriptions	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	MCO shall develop and implement policies and procedures that:					
6.42.4.1	Include the definition of the target population;	P/P for CCMP CCMP descriptions	Full			
6.42.4.2	Include member identification strategies, i.e. through encounter data;	P/P for CCMP CCMP descriptions	Full			
6.42.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	P/P for CCMP CCMP descriptions	Full			
6.42.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	P/P for CCMP CCMP descriptions	Full			
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	P/P for CCMP CCMP descriptions	Full			
6.42.4.6	Include methods for informing and educating members and providers;	P/P for CCMP CCMP descriptions	Full			
6.42.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	P/P for CCMP CCMP descriptions	Full			
6.42.4.8	Address co-morbidities through a whole-person approach;	P/P for CCMP CCMP descriptions	Full			
6.42.4.9	Identify members who require in-person case management services and a plan to meet this need;	P/P for CCMP CCMP descriptions	Full			
6.42.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	P/P for CCMP CCMP descriptions		Full		
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions		Full		
6.44	**CCMP Reporting Requirements**					
6.44.1	The MCO shall submit Chronic Care Management reports quarterly to LDH.	Communications to LDH	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.					
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports	Not applicable			
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports	Not applicable			
6.44.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	CCMC reports	Not applicable			
6.44.3 6.44.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	CCMC reports	Not applicable			
6.45	**Services for Co-occurring Behavioral Health and Developmental Disabilities**					
6.45.1	The MCO shall create a framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co-occurring behavioral health and developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring behavioral health and developmental disability. If a member qualifies for services through OCDD, the MCO shall coordinate with OCDD, LGEs, and support coordinators concerning the care of the member. A Statement of Approval from OCDD shall not preclude services from the MCO.	Care Management Policy	New Requirement	Full	This requirement is addressed in Policy 156.202 IHCM Referral Trigger Criteria and 156.900 Continuity for BH Care Coordination	
6.46	**Applied Behavior Analysis (ABA)**					
	Effective February 1, 2018, the MCO shall cover Applied Behavior Analysis (ABA)	Statement of Covered Benefits		Full	This requirement is address in Policy 153.500 AmeriHealth Caritas	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	services.				Louisiana Covered Benefits and Services	
	The MCO shall coordinate and ensure continuity of care between behavioral health specialists, primary care physicians, and other health care specialists, including but not limited to providers qualified to perform Comprehensive Diagnostic Evaluations (CDE), occupational therapists, physical therapists, and speech therapists as indicated and based on medical necessity criteria for such services.	Care Management Policy		Full	This requirement is addressed in Policy 156.202 IHCM Referral Trigger Criteria and 156.900 Continuity for BH Care Coordination	
	The MCO shall ensure member and provider call center staff and utilization management staff are knowledgeable in ABA services. Staff shall be capable of providing an explanation of ABA services, a list of ABA providers, and information regarding the prior authorization process to members or providers seeking information.	Care Management Policy Training Policy UM Policy and Procedures		Full	This requirement is addressed in the ACLA Training and Orientation Plan for ABA Services	
	ABA service shall not be denied solely because a member does not have an Autism Spectrum Disorder (ASD) diagnosis.	Statement of Covered Benefits		Full	This requirement is addressed in policy BH UM Process Applied Behavioral Analysis (ABA) Requests	

Reporting

Reporting						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
4.5	**Written Policies, Procedures, and Job Descriptions**					
18.0	The MCO shall develop and maintain	P/P MCO Policy		Full	This requirement is addressed in	

Reporting						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	written policies, procedures and job descriptions for each functional area, including for specialized behavioral health services, consistent in format and style. The MCO shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the MCO's written policies reflect current practices. Reviewed policies shall be dated and signed by the MCO's appropriate manager, coordinator, director or administrator.	Development and Approval			policy 285.101 ACLA Annual Job Description Review and Policy 168.302 Development of Policies Procedures.	
18.0	**Reporting**					
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	Screen shot of health informatics system System reports		Full		