



**2025 External Quality Review
Compliance Review**

for

AmeriHealth Caritas Louisiana

December 2025



Table of Contents

1. Executive Summary	1-1
Introduction	1-1
Summary of Compliance Review Results.....	1-2
2. Methodology	2-1
Activity Objectives.....	2-1
Technical Methods of Data Collection and Analysis	2-3
Pre-Virtual Review Activities	2-3
Virtual Review Activities.....	2-3
Post-Virtual Review Activities.....	2-3
Data Aggregation and Analysis.....	2-4
Description of Data Obtained.....	2-5
3. Corrective Action Plan Process	3-1
Appendix A. Conclusions and Recommendations	A-1
Appendix B. 2025 Compliance Review Tool	B-1
Appendix C. 2025 Corrective Action Plan Template	C-1

1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review (CR) activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).¹

¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Apr 1, 2025.

Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for AmeriHealth Caritas Louisiana (ACLA). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	23	1	0	96%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	9	5	1	64%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	15	4	0	79%
IX	Subcontractual Relationships and Delegation	6	6	4	2	0	67%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	32	5	1	86%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		227	217	192	25	10	88%

M=Met, NM=Not Met, NA=Not Applicable

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs’ compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

Table 2-1—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I— Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II— Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III— Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV— Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V— Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI— Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓				-	✓	✓	✓
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

¹ The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the CR, HSAG developed data collection tools, referred to as “CR tools,” to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs’ compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG’s desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG’s preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG’s review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG’s review activities.
- Interviewed MCE key program staff members.
- Conducted an information systems (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE’s key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE’s performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025-September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

3. Corrective Action Plan Process








ACLA is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for ACLA to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring ACLA into full compliance with the deficient requirements. ACLA must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). ACLA's CAP template and evidence of implementation must be submitted to the HSAG SAFE site **no later than 60 calendar days from receipt of the final report**.


The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that ACLA will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought ACLA into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by ACLA in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
	The MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations. The MCE’s policies and procedures ensured that the MCE did not request disenrollment of a member because of an adverse change in the member’s health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.
	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
	The MCE consistently met timeliness requirements for prior authorization decisions. Additionally, the MCE received 100 percent compliance with Standard VII—Coverage and Authorization of Services, demonstrating that the MCE had a thorough and comprehensive approach for review, authorization, and denial of services.
	The MCE effectively adopted practice guidelines in consensus with network providers and had a system in place for dissemination to providers and members. In addition, the MCE received 100 percent compliance with Standard X—Practice Guidelines.
	The MCE demonstrated a robust health information system for processing and managing member data, provider data, and claims processing, while ensuring data security and facilitating data reporting. As a result, the MCE received 100 percent compliance with Standard XI—Health Information Systems.
	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.
	The MCE received 100 percent compliance with Standard XIV—Program Integrity, demonstrating that the MCE had appropriate processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. Furthermore, the MCE developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations	
	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.



Appendix B. 2025 Compliance Review Tool

This appendix includes the completed review tool that HSAG used to evaluate ACLA's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring ACLA's performance into full compliance.



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
Disenrollment Requested by the MCE		
<p>1. The MCE may request disenrollment of a member in the following circumstances:</p> <ul style="list-style-type: none"> a. <i>When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department</i> b. <i>Upon termination or expiration of the Contract</i> c. <i>Death of the member</i> d. <i>Confinement of the member in a facility or institution when confinement is not a covered service under the Contract</i> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The Contractor may request involuntary disenrollment of an enrollee if the enrollee’s utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee’s ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.</i> <p style="text-align: right;">42 CFR §438.56(b)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • State-specific workflow for MCE-initiated disenrollment requests • Member materials, such as the member handbook • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 526-078 – State Notifications for Member Data Changes, page 2 • 2024 Member HB English Version_Audit, p.46 of PDF • ACLA Provider Handbook for December 2024-FINAL, p 121 & 168 of PDF • 532-015 - Disenrollment and Enrollment Process, page 2 and 4 of PDF • EXTERNAL RE: Out of State – SG 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Any MCO initiated requests for disenrollment are routed to ACLA Compliance Director for review and submission to LDH. The Compliance Director validates that the request meets one of the allowed circumstances to request disenrollment and upon confirmation, submits request to LDH for review. ACLA continues to provide all covered services to the member until such time that LDH has disenrolled the member and notified ACLA via 834 file.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE does not request disenrollment because of: MCO & PAHP:</p> <ol style="list-style-type: none"> a. An adverse change in the member’s health status; or b. Because of the member’s health diagnosis c. The member’s utilization of medical services d. The member’s diminished mental capacity e. The member’s pre-existing medical condition f. The member’s refusal of medical care or diagnostic testing g. The member’s attempt to exercise his/her rights under the Contractor’s Grievance system h. The member’s attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCE seriously impairs the MCE’s ability to furnish services to either this particular member or other members). 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 532-015 - Disenrollment and Enrollment Process, see page 2 of PDF • ACLA Requested Disenrollments 2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ul style="list-style-type: none"> a. The member's adverse change in health status b. The member's utilization of medical services c. The member's diminished mental capacity d. The member's uncooperative or disruptive behavior resulting from his or her special needs <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(b)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5</p>		
<p>MCE Description of Process: Any MCO initiated requests for disenrollment are routed to ACLA Compliance Director for review and submission to LDH. The Compliance Director validates that the request meets one of the allowed circumstances to request disenrollment and upon confirmation, submits request to LDH for review. ACLA continues to provide all covered services to the member until such time that LDH has disenrolled the member and notified ACLA via 834 file. In 2024, ACLA had no instances of MCO initiated disenrollments for prohibited reasons.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract.</p> <p>MCO & PAHP:</p> <ul style="list-style-type: none"> a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.</p> <p>PIHP:</p> <p>a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may not disenroll Coordinated System of Care (CSoC) members for any reason other than discharge from CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge.</p> <p style="text-align: right;">42 CFR §438.56(b)(3) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 532-015 - Disenrollment and Enrollment Process, page 3 of PDF EXTERNAL RE Out of State - SG 	
<p>MCE Description of Process: Any MCO initiated requests for disenrollment are routed to ACLA Compliance Director for review and submission to LDH. The Compliance Director validates that the request meets one of the allowed circumstances to request disenrollment and upon confirmation, submits request to LDH for review. ACLA continues to provide all covered services to the member until such time that LDH has disenrolled the member and notified ACLA via 834 file. ACLA does not have any specific training materials for the item; training is side-by-side with a team lead or senior specialist.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
Disenrollment Requested by the Member		
<p>4. The member may request disenrollment from the MCE as follows:</p> <p>a. Without cause, at the following times:</p> <p style="padding-left: 20px;">MCO:</p> <p style="padding-left: 40px;">i. During the disenrollment period offered to Enrollees at the start of the contract.</p> <p style="padding-left: 40px;">ii. During the 90 days following the date of the member’s initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.</p> <p style="padding-left: 40px;">iii. At least once every 12 months thereafter (during the enrollment period).</p> <p style="padding-left: 40px;">iv. At least once every 12 months thereafter.</p> <p style="padding-left: 40px;">v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.</p> <p style="padding-left: 40px;">vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit • Standard I, # 4.a, p. 46 of PDF • 532-015 - Disenrollment and Enrollment Process, page 3 of PDF 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p>PAHP:</p> <p>i. During the 90 days following the date of the member’s initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.</p> <p>ii. At least once every 12 months thereafter.</p> <p>iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.</p> <p>iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.</p> <p>v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p style="text-align: right;">42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
MCE Description of Process: N/A as this is an LDH process with which ACLA complies and over which ACLA has no control.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Procedures for Disenrollment		
<p>5. The following are causes for disenrollment:</p> <p>MCO:</p> <ol style="list-style-type: none"> a. The member moves out of the MCE’s service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; c. The member needs related services to be performed at the same time; not all related services are available from the MCE’s plan, and the member’s primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs; f. The Contract between the MCE and LDH is terminated; g. The member’s active specialized behavioral health provider ceases to contract with the MCE for reasons other than noncompliance with the Network Provider Agreement of this Contract; or h. Any other reason deemed to be valid by LDH and/or its agent. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit • Standard I, p. 46 of PDF • 532-015 - Disenrollment and Enrollment Process, page 3 of PDF 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>PAHP:</p> <ul style="list-style-type: none"> a. The MCE does not (due to moral or religious objections) cover the service the member seeks; b. The member needs related services to be performed at the same time, not all related services are available from the MCE’s plan, and the member’s primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; c. Poor quality of care; d. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs; e. The Contract between the MCE and LDH is terminated; f. Any other reason deemed to be valid by LDH and/or its agent. <p style="text-align: right;">42 CFR §438.56(d)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA</p>		
<p>MCE Description of Process: N/A as this is an LDH process with which ACLA complies and over which ACLA has no control.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>6. The member must request disenrollment by submitting an oral or written request (as required by the State):</p> <p style="margin-left: 20px;">a. To the State or its agent; or</p> <p style="margin-left: 20px;">b. To the MCE, if the State permits MCEs to process disenrollment requests.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(1) 42 CFR §457.1212</p> <p>MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Workflow delineating State and MCE responsibilities Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit Standard I, #6, p.46 532-015 - Disenrollment and Enrollment Process, page 5 of PDF RE LA EB – ACLA AWS Access Testing 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: N/A as this is an LDH process with which ACLA complies and over which ACLA has no control. The Enrollment Broker, Maximus, has been working on establishment of AWS application through Maximus but to date, we have not had success (see evidence RE LA EB – ACLA AWS Access Testing).</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. When the MCE’s contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(3)(i)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	42 CFR §457.1212 member letter, review conducted by the MCE, decision made by the MCE, reporting to the State) Evidence as Submitted by the MCE: <ul style="list-style-type: none"> 532-015 - Disenrollment and Enrollment Process, page 5 of PDF 2024 Member HB English Version_Audit Standard I, #7, p.46 RE LA EB – ACLA AWS Access Testing 	
MCE Description of Process: The Enrollment Broker, Maximus, has been working on establishment of AWS application through Maximus but to date, we have not had success (see evidence RE LA EB – ACLA AWS Access Testing).		
HSAG Findings: The state retains authority over all disenrollment decisions, so the MCE is not able to process a disenrollment request; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Use of the MCE’s Grievance Process		
8. (If the State contract requires) The member must seek redress through the MCE’s grievance process before making a determination on the member’s request: a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State.	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Three case examples of a member request for disenrollment grievance record, including the resolution letter Referrals to the State for member termination from MCE Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request.</p> <p style="text-align: right;">42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
<p>MCE Description of Process: Neither Contract Requirement 2.15 (Enrollee Grievances, Appeals, and State Fair Hearings) nor Contract Requirement 2.3.13 (Disenrollment) require the member to seek redress through ACLA’s grievance process before making a determination on the member’s disenrollment require. Accordingly, there is no evidence to submit.</p>		
<p>HSAG Findings: The state contract does not require a grievance process as described in these requirements; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
<p>9. the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 532-015 - Disenrollment and Enrollment Process, page 5 of PDF 	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: N/A as this is an LDH process with which ACLA complies and over which ACLA has no control.</p>		
<p>HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
Enrollment		
<p>10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems.</p> <p>MCO and PAHP:</p> <p>a. <i>The Contractor shall accept new+ Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 CFR §438.50(a).</i></p> <p>PIHP:</p> <p>a. <i>The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member’s choice. The WAA shall ensure that the</i></p>	<p>HSAG Required Evidence:</p> <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit Standard I, #10, p.59 of PDF 532-015 - Disenrollment and Enrollment Process, page 6 of PDF 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>independent assessment is conducted to determine clinical eligibility.</i></p> <p style="text-align: center;">42 CFR §438.3(d)(1)</p> <p>MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2</p>		
MCE Description of Process: All members sent to ACLA via the 834 file are loaded and ACLA does not perform any screening on members prior to loading.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>11. The MCE does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability.</p> <p style="text-align: center;">42 CFR §438.3(d)(3-4)</p> <p>MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit Standard I, p.59 of PDF • 532-015 - Disenrollment and Enrollment Process, page 6 of PDF 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>12. If the Department approves the MCE’s disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member notification letter template <p>Evidence as Submitted by the MCE:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>MCO:</p> <p>a. The notice shall include:</p> <p style="margin-left: 20px;">i. The reason for the disenrollment;</p> <p style="margin-left: 20px;">ii. The effective date of the disenrollment;</p> <p style="margin-left: 20px;">iii. An instruction that the Enrollee choose a new MCO; and</p> <p style="margin-left: 20px;">iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing.</p> <p>PAHP:</p> <p>a. The notice shall include:</p> <p style="margin-left: 20px;">i. The reason for the disenrollment;</p> <p style="margin-left: 20px;">ii. The effective date;</p> <p style="margin-left: 20px;">iii. An instruction that the enrollee choose a new DBPM; and</p> <p style="margin-left: 20px;">iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(5)</p> <p>MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA</p>	<ul style="list-style-type: none"> 532-015 - Disenrollment and Enrollment Process, page 4-5 of PDF <p>Additional Documentation:</p> <ul style="list-style-type: none"> Template notification standardized language 	
<p>MCE Description of Process: The Enrollment Department will be alerted to an identified non-compliant member through an email to DL-ACLA: Enrollment sent from the Medical Affairs staff. Enrollment will notify ACLA Compliance of the MCO request for disenrollment, who will review and upon approval, submit to LDH. If the MCO request for disenrollment is approved by LDH, the Enrollment Department will create and mail a written notice to the member, which will cite the circumstances and the consequences of non-compliant behavior. A copy of the letter will be maintained in the member’s folder and may be sent to the member’s primary care provider. The letter will contain the reason</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
for the disenrollment request, and an explanation that the plan is requesting that the member be disenrolled in the month following member notification.		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendation: HSAG recommends that ACLA revise the Disenrollment and Enrollment Process policy to indicate that the disenrollment letter will contain all requirements, as listed.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	Total Score		=	9
Total Score ÷ Total Applicable						=	100%



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
General Rule		
1. The MCE has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2	HSAG Required Evidence: <ul style="list-style-type: none"> Member rights policy Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Policy 669-249 Member Rights and Responsibilities: Entire policy Policy 669-218 Notice of Privacy Practices: page 2-3, section 5(a)-5(f). 2024 Member Handbook English Version: page 47 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: AmeriHealth Caritas Louisiana (ACLA) has policies and procedures in place to ensure member rights are upheld and our employees receive regular training to reinforce their responsibility to observe and protect member rights in all aspects of their work.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it's employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and Procedures Provider materials, such as the provider manual, provider contract, and provider training materials Employee training materials Auditing/oversight mechanisms Grievance log over the time period of review with member rights grievances 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy: 669-249 Member Rights and Responsibilities: Entire Policy Training Material: HIPAA 2024-2025 (eLearning): page 22-25, section 5. 2024 Member Handbook English Version: page 47 ACLA Provider Handbook for December 2024: page 215-216 All MCO PQM Strategy_Final July 2024 ACLA Ancillary-Service Agreement (08-01-2022), Section 6 Confidentiality ACLA Hospital- Service Agreement (08-01-2022), Section 6 Confidentiality ACLA PCP- Service Agreement Template (08-01-2022), Section 6 Confidentiality ACLA Specialist- Service Agreement (08-01-2022), Section 6 Confidentiality Behavioral Health Provider Orientation (pptx) Physical Health Provider Orientation (pptx) Standard II_ Member Rights and Confidentiality- Grievance log 2024 (excel) 	
<p>MCE Description of Process: ACLA complies with all applicable Federal and State laws that protect member rights. We have policies and procedures in place to ensure these rights are upheld and our employees receive regular training to reinforce their responsibility to observe and protect member rights in all aspects of their work.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
Specific Rights		
<p>3. The MCE complies with the requirements listed in the Member Rights Checklist.</p> <p style="text-align: right;">42 CFR §438.100(b-d) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures Member materials, such as the member handbook HSAG will also use the results of the Member Rights Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-218 Notice of Privacy Practices: page 2-3 Notice of Privacy Practices: Entire Document Policy 669-249 Member Rights and Responsibilities: Entire policy 2024 Member Handbook English Version: page 47 Refer to the Member Rights Checklist 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Please see the Member Rights Checklist for the specific area of noncompliance.		
Required Actions: The MCE must revise its contracts, trainings, and provider orientation materials to include the member’s right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.		
General Rule		
<p>4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures (should address all components of 45 CFR part 164 subpart E) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.</p> <p>a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO.</p> <p>b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520.</p> <p>c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530.</p> <p>d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.</p> <p style="text-align: right;">42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E</p> <p>MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12</p>	<ul style="list-style-type: none"> • Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-101 Confidentiality: page 5-6, section B.1-B.8. • Policy 669-200 Authorization to Use or Disclose PHI: Entire Policy • Policy 669-206 Disclosure of PHI As Required by Law: Entire Policy • Policy 669-208 Disclosures of PHI to Personal Representatives: Entire Policy • Policy 669-209 Disclosure of PHI to BAs and Other Contractors: Entire Policy • Policy 669-213 Safeguards to Avoid Disclosures of PHI PII Sensitive Data: Entire Policy • Policy 669-214 Limited Data Set: Entire Policy • Policy 669-216 Providing Medical Info to Others Involved in Care: Entire Policy 	<input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Policy 669-217 Minimum Necessary Standard: Entire Policy • Policy 669-218 Notice of Privacy Practices: Entire Policy • Policy 669-226 Training Program - Uses Disclosures Safeguarding PHI: Entire Policy (11c). • Policy 669-227 Use Disclosure PHI WO Member Auth: Entire Policy • Policy 669-228 Accounting Of Disclosures Of PHI: Entire Policy • Policy 669-230 Complaints and Requests Regarding Privacy Practices: page 1, section 1.A; page 2, section 1.B-1.D. • Policy 669-249 Member Rights and Responsibilities: Entire Policy • Training Material_HIPAA 2024-2025 (eLearning): Entire Document • Authorization for Disclosure Form Template: Entire Document • Consent Management Overview and Workflow: Entire Document • Consent Management Process_Redacted: Entire Document • HIPAA Training Tracking - eLearning Platform_Redacted: Entire Document • ACLA Ancillary-Service Agreement (08-01-2022), Section 9.7 Confidentiality 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> ACLA Hospital-Service Agreement (08-01-2022), Section 9.7 Confidentiality ACLA PCP-Service Agreement Template (08-01-2022), Section 9.7 Confidentiality ACLA Specialist-Service Agreement (08-01-2022), Section 9.7 Confidentiality <p>Additional Documentation:</p> <ul style="list-style-type: none"> VP Chief Compliance Officer Job Description Director Privacy Job Description 	
<p>MCE Description of Process: AmeriHealth Caritas Louisiana (ACLA) complies with the requirements outlined in 45 CFR § 164.530 as well as 45 CFR 160 and 164, Subparts A and E. AmeriHealth Caritas has an enterprise Privacy Office, including an appointed Privacy Officer, that is responsible for oversight of the privacy function including, but not limited to, safeguarding of member Protected Health Information (PHI), privacy incident investigation, member rights request fulfillment, handling of member privacy complaints, and Breach notifications as required. In addition, the ACLA Compliance Director also serves as the MCE Privacy Officer and partners with the Privacy Office on ACLA related matters. The Privacy Office and ACLA Compliance team meet regularly to review privacy incidents, trending topics, and discuss upcoming initiatives that may have privacy implications.</p> <p>The Privacy Office has implemented appropriate administrative, technical, and physical safeguards to protect the privacy of member PHI, in accordance with the HIPAA Privacy Rule. Our policies and procedures are reviewed at least annually and updated as necessary to reflect any regulatory or procedural changes. Employees are trained on HIPAA requirements upon hire and annually thereafter to ensure continued compliance and protection of member PHI.</p> <p>The MCE also has an enterprise Information Security (IS) department who is responsible for the security of the systems that contain member PHI. In particular, IS also has safeguards to identify potential PHI being distributed via email outside of ACFC’s email domain and ensures the email is properly secured. IS prevents the distribution of emails not following established protocol and notifies the associate and supervisor of the non-compliance, to remediate the issue and prevent recurrence.</p> <p>AmeriHealth Caritas also has dedicated Privacy and Security Counsel to assist in any privacy and security matters and lead the negotiation of Business Associate Agreements with contracted vendors and subcontractors.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosure of PHI		
<p>5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows:</p> <ol style="list-style-type: none"> a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). <p style="text-align: right; margin-right: 20px;"> 45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 </p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-200 Authorization to Use or Disclose PHI: Entire Policy • Policy 669-206 Disclosure of PHI As Required by Law: Entire Policy • Policy 669-208 Disclosures of PHI to Personal Representatives: Entire Policy • Policy 669-209 Disclosure of PHI to BAs and Other Contractors: Entire Policy • Policy 669-213 Safeguards to Avoid Disclosures of PHI PII Sensitive Data: Entire Policy • Policy 669-214 Limited Data Set: Entire Policy • Policy 669-216 Providing Medical Info to Others Involved in Care: Entire Policy; (5e) page 3, sections 3 & 4; page 4-5, sections 2 & 3. • Policy 669-217 Minimum Necessary Standard: Entire Policy 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2</p>	<ul style="list-style-type: none"> Policy 669-226 Training Program - Uses Disclosures Safeguarding PHI: page 1-2, sections A-E. Policy 669-227 Use Disclosure PHI WO Member Auth: Entire Policy; (5a) page 4, section B(c)(ii); (5b) page 2-4, sections B(1) & B, (2c) page 2, section A(1)–A(4), page 4, section B(3)(c)(i); (5f) page 4-5, section B(3)(d) – B(3)(f). Training Material_HIPAA 2024-2025 (eLearning): pages 8-14, Section 2 Business Associate Agreement Template: Entire Document Executed Business Associate Agreement Example_Redacted: Entire Document 	
<p>MCE Description of Process: ACLA and our Business Associates comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and only use or disclose PHI as permitted or required by law. This includes uses and disclosures for treatment, payment, and health care operations, as well as those made with a valid member authorization or as otherwise allowed under 45 CFR Part 164, Subpart E. We maintain comprehensive privacy policies and procedures which govern the appropriate use and disclosure of PHI, and we provide regular training to our employees to ensure ongoing compliance. All uses and disclosures are reviewed to ensure they meet HIPAA’s minimum necessary standard are consistent with members’ privacy rights.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Business associate agreement template 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528.</p> <p>b. When required by the Secretary to investigate or determine the MCE’s compliance with 45 CFR §160 subpart C.</p> <p style="text-align: right;">45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> • One example of an executed business associate agreement <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-249 Member Rights and Responsibilities: (6a) Page 3-5, Section B, “Right to Inspect/Access PHI” • Policy 669-228 Accounting of Disclosures of PHI: (6a) Entire Policy • Policy 669-206 Disclosure of PHI As Required by Law: (6b) pages 7-8, section F. • Training Material_HIPAA 2024-2025 (eLearning): page 23, Section 5.2 • Business Associate Agreement Template: pages 7-8, sections VI.A.1, VI.B, VI.C, & VI.E. • Executed Business Associate Agreement Example_Redacted: page 7-8, section sections VI.A.1, VI.B, VI.C, & VI.E. 	
<p>MCE Description of Process: In accordance with 45 CFR §164.502(a)(2-4) ACLA uses and disclosed PHI only as permitted or required under HIPAA, including for treatment, payment, health care operations, and as authorized by the individual or required by law. Our Business Associates use or disclose PHI only as permitted or required under the Business Associate Agreement (BAA) contract with ACLA or as required by law. Pursuant to §164.524, we honor an individual’s right to access their PHI maintained in a DRS and ensure those requests are processed timely and within a format requested, when feasible. In the event the individual’s request would include records held by a Business Associate, ACLA would work with the Business Associate to obtain those records. In compliance with 45 CFR §164.528 we maintain and provide individuals with an accounting of certain disclosure of the PHI upon request, in accordance with the content and timeframe requirements established under HIPAA. In the event the individual’s accounting request would include disclosures made by a Business Associate, ACLA would work with the Business Associate to obtain those disclosures to include within a comprehensive list. Additionally, we comply with 45 CFR Part 160, Subpart C, which addresses compliance and enforcement provisions, including cooperation with the U.S. Department of HHS during investigations and audits. We have established policies and procedures, conducted regular employee training, and</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>implemented appropriate safeguards to ensure full compliance with these Federal requirements. Our Business Associates are also required to disclose PHI when required under this regulation to ensure their compliance with the subchapter. Our Business Associate Agreements outline these expectations of our Business Associates.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Minimum Necessary		
<p>7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.</p> <p style="text-align: right;">45 CFR §164.502(b) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Three examples of requests for PHI from another covered entity (e.g., member’s previous MCE, dental benefits administrator, provider) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-217 Minimum Necessary Standard: Entire Policy Policy 669-227 Use Disclosure PHI WO Member Auth: page 2, section “Policy”; page 2, sections A.1-A.4; page 3, section 2(a). Training Material_HIPAA 2024-2025 (eLearning): page 15-17, section 3. Examples of requests for PHI _Standard II Element 7 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA complies with HIPAA’s Minimum Necessary Standard as outlined within 45 CFR §164.502(b) and §164.514(d). Policies outline that we limit the use, disclosure, and request of PHI to the minimum amount necessary to accomplish the intended purpose. This applies to internal employee access as well as when disclosing PHI to, or requesting it from, other covered entities or contracted business associates. We have policies in place that guide staff on minimum necessary practices, and we provide training to ensure understanding and compliance across all functional areas.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>8. Minimum necessary does not apply to:</p> <ul style="list-style-type: none"> a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. <p style="text-align: right; margin-right: 20px;"> 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 </p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-217 Minimum Necessary Standard: page 2, section “Exceptions” 1-4. • Policy 669-227 Use Disclosure PHI WO Member Auth: pages 2-6, sections B.1-B.3. • Training Material_HIPAA 2024-2025 (eLearning): pages 8-12, section 2; pages 15-17, section 3. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies with HIPAA’s Minimum Necessary Standard and understands and applies specific exceptions. These exceptions include:</p> <ul style="list-style-type: none"> - Disclosures to or requests by a healthcare provider for treatment purposes - Disclosures to the individual who is the subject of the PHI - Use or disclosures made pursuant to a valid authorization 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> - Disclosures to the U.S. Department of HHS for compliance and enforcement - Uses or disclosures that are required by law <p>Our employees are trained to identify when the minimum necessary standard applies and when it does not, ensuring appropriate use and protection of member information in all situations.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosures Requiring Authorizations		
<p>9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization.</p> <p>a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization.</p> <p style="text-align: right;">45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4) 45 CFR Part 164 Subpart E 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-200 Authorization to Use or Disclose PHI: page 1-6, section “Policy”, section A.1-A.5, section “Purpose”; page 11, section A.1-A.4; page 11-12, section B.1-B.4; page 12, section C.1-C.3; page 13, section D.1. • Training Material_HIPAA 2024-2025 (eLearning): Section 2, page 10-14. • Consent Management Process_Redacted: Entire Document • Consent Management Overview and Workflow: Entire Document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Authorization for Disclosure Form Template: Entire Document Signed Authorization Example 1_Redacted Signed Authorization Example 2_Redacted <p>Additional Documentation:</p> <ul style="list-style-type: none"> Accounting of Disclosures of PHI 2024 Q2 2024 Compliance Committee Meeting Minutes 	
<p>MCE Description of Process: ACLA complies with 45 CFR Part 164, Subpart E, which governs the use and disclosure of PHI under the HIPAA Privacy Rule. When an authorization is required, we obtain a valid, HIPAA-compliant authorization prior to using or disclosing PHI. Additionally, we ensure that individuals receive a copy of the signed authorization form, as required by 45 CFR §164.508(c)(4). Our policies and procedures support these requirements, and employees are trained to follow proper authorization processes to safeguard member privacy and PHI.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Privacy Rights		
<p>10. The MCE complies with the member’s right to request privacy protection for PHI and the requirements under 45 CFR §164.522.</p> <p style="text-align: right;">45 CFR §164.522 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Process workflow Member request form for privacy protection Two examples of member’s request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-249 Member Rights and Responsibilities: page 5-6, section “Requests to Restrict the Use or Disclosure of PHI”; page 8, section C. Training Material_HIPAA 2024-2025 (eLearning): Section 5, page 22-25. Training Material_Member Request to Restrict PHI: Entire Document. Training Material_Member Request for Alternative Means of Communication: Entire Document. Request to Restrict Use or Disclosure of PHI Form Template 	
<p>MCE Description of Process: ACLA complies with 45 CFR §164.522, which outlines individuals’ rights to request privacy protections for PHI. We honor members’ rights to request restrictions of certain uses and disclosure of their PHI and request confidential communications through alternative means or alternative locations. We have established procedures to review, document, and accommodate these requests when appropriate, and our employees are trained to ensure these rights are respected in accordance with HIPAA requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The MCE complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.</p> <p style="padding-left: 20px;">a. The MCE acts on a request for access no later than 30 days after receipt of the request.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Process workflow Member request form to access PHI 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member.</p> <p style="text-align: right;">45 CFR §164.524 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Two examples of member’s request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-249 Member Rights and Responsibilities: page 2-3, section B; page 3-5, section “Right to Inspect/Access PHI”. Training Material <u>HIPAA 2024-2025 (eLearning):</u> Section 5, page 22-25. Training Material <u>Member Request to Inspect or Access PHI: Entire Document</u> Request to Inspect or Access PHI in DRS Form Template 2024 Member Medical Record Requests Examples <p>Additional Documentation:</p> <ul style="list-style-type: none"> Member Request Tracking Log 	
<p>MCE Description of Process: ACLA complies with 45 CFR §164.524, which provides individuals with the right to access or obtain a copy of their PHI maintained in a Designated Record Set (DRS). We have policies and procedures in place to ensure timely process of access requests, including verifying the identify of the requestor, providing access in the requested format when feasible, and response within the required timeframes. Our employees are trained to supper this process and to uphold member rights in accordance with HIPAA regulations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>12. The MCE complies with the member’s right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526.</p> <ul style="list-style-type: none"> • The MCE acts on the member’s request for an amendment no later than 60 days after receipt of such a request. <p style="text-align: right;">45 CFR §164.526 42 CFR §457.1110(e)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Process workflow • Member request form to amend PHI • Two examples of member’s request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request • One example of a denial of an amendment and notification to the member <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-249 Member Rights and Responsibilities: pages 6-8, sections 1-7 of “Right to Amend PHI”. • Training Material_HIPAA 2024-2025 (eLearning): Section 5, page 22-25. • Training Material_Member Request to Amend PHI: Entire Document • Policy, SOP, or screenshot of member portal that demonstrates process for member to request amendment of PHI. • Two examples of member’s request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request. • Evidence of how MCE documents PHI amendment requests and tracks to ensure response in 60 days. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Member Request Tracking Log Member Rights & Responsibilities, pgs. 6-8, 17-19 	
MCE Description of Process: ACLA complies with 45 CFR §164.526, which grants individuals the right to request an amendment of their PHI maintained in a DRS. We have policies and procedures in place to review and respond to amendment requests in a timely manner, including providing written responses and the opportunity for members to submit a statement of disagreement if an amendment is denied. Our employees are trained to ensure that all amendment requests are handled in accordance with HIPAA requirements, and that member rights are fully respected.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. The MCE complies with the member’s right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. <ol style="list-style-type: none"> a. The MCE acts on the member’s request for an accounting, no later than 60 days after receipt of such a request. b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). <p style="text-align: right;">45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110</p> MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Staff training materials Process workflow Member request form for an accounting of disclosures of PHI Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) Two examples of member’s request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request Documentation to demonstrate how the record of the accounting of disclosures is retained 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
PIHP Contract: HIPAA Business Associate Addendum	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-228 Accounting of Disclosures of PHI: Entire Document Training Material_HIPAA 2024-2025 (eLearning): Section 5, page 22-25. Training Material_Accounting of Disclosures Request: Entire Document Screenshot of ACLA Accounting of Disclosures Tracking Log_Redacted: Entire Document Accounting Of Disclosures Log SharePoint User Guide: Entire Document 	
<p>MCE Description of Process: ACLA complies with 45 CFR §164.528, which provides individuals the right to request an accounting of certain disclosures of their PHI. We maintain the necessary documentation to track applicable disclosures and have procedures in place to respond to member requests for an accounting within the required timeframes. In addition, we comply with 45 CFR §164.530(j), which outlines documentation requirements under the HIPAA Privacy Rule. We retain all required policies, procedures, and communications – including privacy practice notices, authorization, and complaints – for a minimum of six (6) years from the date of creation of the date they were last in effect, whichever is later. Our employees are trained on these requirements to ensure ongoing compliance and protection of member privacy rights. There were no member requests received for an accounting of disclosures during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Breach of Unsecured PHI		
14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Breach notification letter template Incident risk assessment tool 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>have been accessed, acquired, used, or disclosed as a result of such breach.</p> <p>a. Breach and unsecured PHI are as defined in 45 CFR §164.402.</p> <p style="text-align: right;">45 CFR §164.402 45 CFR §164.404(a)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Unauthorized disclosure/breach tracking mechanism List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 7-8, sections B.5 & C.7-C.8. Breach Notification Letter Template: Entire Document RADAR User Guide-Desktop Reference: pages 5-6, 8, 9, 10, 23-25. Risk Assessment Tool: Entire Document RADAR Privacy Incident Case Example_Redacted: Entire Document ACLA 2024 Breach List 	
<p>MCE Description of Process: ACLA complies with 45 CFR §164.402 and §164.404(a)(1) related to the HIPAA Breach Notification Rule. We have established policies and procedures to assess potential breaches of unsecured PHI in accordance with the definition and risk assessment standards set forth in §164.402. When a Breach is determined to have occurred, we notify the affected individuals without reasonable delay and no later than 60 calendar days from the discovery of the Breach, as required under §164.404(a)(1). Our employees are trained to report suspected or actual Breaches through outlined channels, while our Privacy Office and Compliance employees are trained to recognize and report Breaches, and we maintain documentation of all Breach investigations and notifications in compliance with HIPAA requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Incident risk assessment tool 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE.</p> <p>a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the MCE.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Unauthorized disclosure/breach tracking mechanism List of all breaches of unsecured PHI during the time period under review, including the date of discovery <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 2, section “Policy”; page 2, section D of “Purpose”. RADAR User Guide-Desktop Reference: pages 5, section V. Risk Assessment Tool: page 1 RADAR Privacy Incident Case Example_Redacted: page 1-2. AmeriHealth Caritas Corporate Privacy Checklist: page 1, section f(i)(2). AmeriHealth Caritas Corporate Compliance and Privacy Incident Playbook: page 4, section 2(b)(i)(1)(b). ACLA 2024 Breach List 	<input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies with the HIPAA Breach Notification Rule as outlined in 45 CFR §164.404(a)(1), §164.406(a), and §164.408(a). In accordance with §164.404(a), we notify affected individuals without reasonable delay and no later than 60 calendar days after discovery of a Breach of unsecured PHI. Discovery date of a Breach would constitute the first day anyone within the MCE knew of the incident. As required under §164.406(a), for Breaches affecting more than 500 residents of a state or jurisdiction, we promptly provide notification to prominent media outlets serving the affected area. Additionally, we comply with §164.408(a), by notifying the Secretary of U.S. Department of Health and Human Services (HHS) of all reportable Breaches through the required online portal, within the timeframes specified based on the number of impacted individuals. Our Breach response policies and procedures are well established, and our Privacy Office and Compliance employees are trained to ensure timely detection, investigation, documentation, and notification in accordance with Federal regulations.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach.</p> <p style="text-align: right;">45 CFR §164.404(b) 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 2, section “Policy”; page 10, section C.16. • ACLA 2024 Breach List • Breach Notification Letters Sent to Members Examples_Redacted 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies 45 CFR §164.404(b), ensuring that individual Breach notification letters contain all required elements, including a description of the Breach, the types of information involved, the steps individuals should take to protect themselves, what the health plan is doing to investigate and mitigate the Breach, and contact information for further assistance. Notifications are written in plain language and provided within the required timeframe. We also comply with 45 CFR §164.412, by ensuring that all required notifications are made without reasonable delay and no later than 60 calendar days after the Breach is discovered. We have policies and procedures in place to promptly assess, document, and respond to potential Breaches of unsecured PHI, and our Privacy Office and Compliance employees are trained to support timely and compliant Breach response activities.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible:</p> <p>a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.</p> <p>b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).</p> <p>c. Any steps individuals should take to protect themselves from potential harm resulting from the breach.</p> <p>d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.</p> <p>e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(c)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 7-9, section C.7-C.9. • Breach Notification Letter Template: Entire Document • Breach Notification Letters Sent to Members Examples_Redacted • Breach Notification Letter Template with Grade Level 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA complies 45 CFR §164.404(c) and §164.406(c) as part of our responsibilities under the HIPAA Breach Notification Rule. In accordance with §164.404(c), our individual Breach notification letters include all required content elements, including: a brief description of the Breach; the types of PHI involved; steps individuals should take to protect themselves; a description of the actions we</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>are taking to investigation the incident, mitigate harm, and prevent future occurrences; and contact information for further inquiries. As required by §164.406(c), any media notifications issued for Breaches affecting more than 500 individuals in a state or jurisdiction include the same required elements as individual notifications to ensure transparency and compliance. We maintain policies and procedures to ensure timely, complete, and accurate Breach notifications, and our Privacy Office and Compliance employees are trained on these requirements to support compliance with HIPAA regulations.</p> <p>There were no applicable incidents that required media notification during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>18. The notification must be provided in the following form:</p> <ol style="list-style-type: none"> a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. <p style="text-align: right;">45 CFR §164.404(d)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Confirmation of first-class mailing <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 7-8, section C.7 • SOP 669-501 Incoming & Outgoing Privacy Office Mail: page 2-3, section 2(a)-2(c). • Confirmation of Mailing Example_Redacted: Entire Document 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA complies 45 CFR §164.404(d)(1), which outlines the methods of notification for Breaches of unsecured PHI. We notify affected individuals without unreasonable delay and no later than 60 calendar days from the discovery of a Breach, using first-class mail to the individual’s last known address. If the individual is deceased, we send the notification to the individual’s next of kin or</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>personal representative, if known, also by first-class mail. In cases where we have insufficient or out-of-date contact information for 10 or more affected individuals, we provide substitute notice through a conspicuous posting on our website or by means of a major print or broadcast media outlet, consistent with HIPAA requirements. In the event new information is discovered, follow up notification with additional details will be provided to the impacted individuals. Our Breach notification policies and procedures support compliance with these requirements, and our Privacy Office and Compliance employees are trained to follow them accordingly.</p> <p>All breaches that impacted ACLA members in 2024 were vendor breaches, as such the breach notification letters were mailed by the vendors. If ACLA mails breach notification letters to members, letters are sent via UPS with tracking. Included as evidence is an example of the type of confirmation that ACLA would retain if ACLA were to mail the letters.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided.</p> <p>a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means.</p> <p>b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must:</p> <p>i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE’s website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period • One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 8, section C.8(a)-(e). • Substitute Notice Script Example_Redacted: Entire Document • Substitute Notice for Plan Website and Member Portals 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual’s unsecured PHI may be included in the breach.</p> <p>c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii).</p> <p style="text-align: right;">45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> Duty to Report Breaches, pg 8 CHC Message w link to CHC Substitute Notice Screenshot of Substitute Notice for CHC Substitute Notice Script, Last Paragraph Note: Change Healthcare was unable to provide ACLA with a definitive list of members that were impacted by the incident. As such, ACLA opted to post substitute notice to the plan website which directed members to a link to CHCs substitute notice with instructions to contact the call center set up by Change Healthcare for further information. An example script has also been included for review as there were no additional incidents that required ACLA to post substitute notice in 2024. 	
<p>MCE Description of Process: ACLA complies with 45 CFR §164.404(d)(1)(ii), which allows for substitute notifications, such as email if the individual has agreed to such electronic communications, to impacted individuals. We also comply with 45 CFR §164.404(d)(2) in cases where we have insufficient or out-of-date contact information for 10 or more affected individuals, we provide substitute notice through a conspicuous posting on our website for a period of 90 days or by means of a major print or broadcast media outlet, consistent with HIPAA requirements. A toll-free phone number is also provided, for a minimum of 90 days, within notification letters for individual’s use in the event they have additional questions or concerns. These processes are documented in our Breach notification policy and our Privacy Office and Compliance employees are trained to ensure timely and accurate reporting consistent with HIPAA regulations.</p> <p>There was an example of one instance in 2025 where ACLA had insufficient or out-of-date contact information for an impacted member and direction was sought from LDH. We are happy to support that evidence if desired. There were no other such incidents to report for 2024.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1).</p> <p style="text-align: right;">45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 2, section “Policy”; page 7, section B.5; page 7, section B.7. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Duty to Report Breaches 2024, pg 7 • Duty to Report Breaches 2025, pg 8 • Note: The 2024 policy referenced above indicates that ACLA will notify impacted individual as required by HIPAA (P.L. No. 104-191, 110 Stat. 1938 (1996), HITECH or applicable state law, however during our annual review it was identified that the policy did not explicitly outline the requirements for imminent misuse notification. The policy was updated during our 2025 review cycle to include this requirement. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies 45 CFR §164.404(d)(3) which requires a covered entity to notify an affected individual via other means in the event of an urgent situation. In the event we encounter a Breach situation where there is the possibility of imminent misuse of unsecured PHI, affected individuals would be notified promptly via a telephone call with follow up written notice provided. This practice is outlined in our Breach notification policy and procedures. Our Privacy Office and Compliance employees are trained to ensure timely and accurate reporting consistent with HIPAA requirements.</p> <p>There were no applicable urgent situations that required member notice during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(a-b)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-234 Duty to Report Incident Breaches of PHI PII: page 8-9, section C.9; page 10, section C.16. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies 45 CFR §164.406, which requires notification to the media in the event of a Breach of unsecured PHI affecting more that 500 individuals in a single state or jurisdiction. In accordance with 45 CFR §164.406(a), when such Breach occurs, we promptly notify prominent media outlets service the area without reasonable delay and no later than 60 calendar days from discovery. The media notification includes the same require elements as the individual notice, as specified in 45 CFR §164.404(c), to ensure transparency and accountability. We maintain policies and procedures to guide the media notification process, and our Privacy Office and Compliance employees are trained to ensure timely and accurate reporting consistent with HIPAA requirements.</p> <p>There were no breaches impacting more than 500 members during the review period.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary.</p> <p>a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site.</p> <p>b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Annual notification to HHS of breaches of unsecured PHI, including the date of notification <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-234 Duty to Report Incidents Breaches of PHI PII: page 9, section C.10; page 9-10, section C.12; page 10, section C.16. ACLA 2024 Breach List Breach Notification to HHS 1 Breach Notification to HHS 2 	
<p>MCE Description of Process: ACLA complies with the HIPAA Breach Notification Rule as outlined in 45 CFR §164.408, which requires notification to the Secretary of the U.S. Department of HHS following a Breach of unsecured PHI. For breaches affecting 500 or more individuals, we report to HHS in conjunction with individual notifications and without reasonable delay, and no later than 60 calendar days from discovery. For Breaches affecting fewer than 500 individuals, we maintain a log of such Breaches and submit the Breach reports to HHS no later than 60 days after the end of the calendar year in which the Breach occurred, as required. Additionally, where applicable, we would comply with 45 CFR §164.412, which requires that Breach notifications be provided only after taking any necessary measures to prevent a criminal investigation from being impeded. If a law enforcement official states that notification would impede a criminal investigation or cause damage to national security, we will delay notification in accordance with the official’s request and the timeframe permitted under the regulation. Our Breach response policies ensure full compliance with these requirements and the Privacy Office and Compliance staff are trained to respond appropriately to Breach events and related reporting obligations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach.</p> <p>a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate.</p> <p>b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.</p> <p>c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach.</p> <p>d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available.</p> <p style="text-align: right;">45 CFR §164.404(c)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 669-209 Disclosure of PHI to BAs and Other Contractors: page 5, section D(1)(o). • ACLA 2024 List of Breaches Reported by Business Associates • Executed Business Associate Agreement Example_Redacted • LDH Checklist_Verida • Executed Subcontractor Contract_Verida_ALCA Amend No.6 • Executed Subcontractor Contract_Verida_ACLA_Amend No.7 • Executed Subcontractor Contract_Verida ACLA Amend No.8 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Disclosure of PHI to BAs, pg 4 & 5 • Executed BAA Example, pg 6 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">45 CFR §164.410 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Note: Policy requires Business Associates to notify ACLA of privacy and security incidents within the timeframe specified in the contract. The executed BAA example provided requires the Business Associate to notify ACLA immediately upon discovery of an incident and then provide any additional information within 18 days. 	
<p>MCE Description of Process: ACLA ensures that all Business Associates comply with the HIPAA Breach Notification Rule in accordance with 45 CFR §164.410. We have executed BAAs with all entities that create, maintain, or transmit PHI on our behalf. These agreements include provisions requiring Business Associates to promptly report any Breach of unsecured PHI to us and with as much detail as possible. We also conduct due diligence checks during the contracting process and periodically review our Business Associate’s compliance with various requirements including the HIPAA regulations. In the event of a Business Associate Breach, we would partner with the vendor to ensure appropriate notifications are made timely and in accordance with all HIPAA requirements. Through strong contractual requirements, oversight, and collaboration we ensure that our Business Associates support our ongoing HIPAA compliance and commitment to member privacy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notice of Privacy Practices		
<p>24. The MCE’s members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member’s rights and the MCE’s legal duties with respect to PHI.</p> <p>a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1).</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Process for disseminating Notice of Privacy Practices Staff training materials Copy of Notice of Privacy Practices Link to Notice of Privacy Practices on the MCE’s website 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c).</p> <p style="margin-left: 40px;">45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669-218 Notice of Privacy Practices: Entire Policy Notice of Privacy Practices: Entire Document Training Material_HIPAA 2024-2025 (eLearning): page 22-25, section 5. Link to Notice of Privacy Practices on ACLA website: https://www.amerihhealthcaritasla.com/pdf/member/rights/npp.pdf 	
<p>MCE Description of Process: ACLA complies with the HIPAA requirement to provide a Notice of Privacy Practices (NPP) to all members outlined in 45 CFR §164.520. The NPP informs members of their rights under HIPAA, our legal duties as a covered entity, and how we use and disclose their PHI. We provide the NPP to member at the time of enrollment, provide additional copies upon request, and have it prominently posted on our plan website. When material changes are made to the notice, we update the version available online and inform members of the revised version. Our policies and procedures ensure proper distribution and accessibility of the NPP, and our employees are trained to assist members in understanding their privacy rights.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	23	X	1	=	23
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	24	Total Score		=	23

Total Score ÷ Total Applicable	=	96%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	Required Components	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10. Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 2, section “Policy”; page 14, section 1(a)(i)-(iv). 2024 Member HB English Version_Audit, page 47 In virtual review, ACLA’s staff members described that member services staff are able to view a member’s primary language. A member must request an alternative version. If speaking to a Spanish interpreter, the member will be sent a Spanish version. If large print or braille is needed, the request would be routed to another department.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy. Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 2, section “Policy”; page 14, section 1(b); page 21, section “Attachment A”. 2024 Member HB English Version_Audit, page 47 In virtual review, ACLA’s staff members described 10 audits per month per associate are conducted to ensure members are treated with respect and with due consideration for his or her dignity and privacy. In addition, ACLA conducted live monitoring of calls throughout each day. Supervisors would provide coaching to improve performance, if needed.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 14, section 1(c) & 1(l); page 21, section “Attachment A”. 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights Checklist		
Reference	Required Components	
MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	<ul style="list-style-type: none"> 2024 Member HB English Version_Audit, page 47 In virtual review, ACLA’s staff members described that a nurse hotline is included in delegate audits. Call scripts and member calls are reviewed.	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 MCO Contract: 2.9.32.1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 14, section 1(l)-(m). 2024 Member HB English Version_Audit, page 47 	
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 2, section “Policy”; page 15, section 1(q); page 21, section “Attachment A”. 2024 Member HB English Version_Audit, page 47 In virtual review, ACLA’s staff members described that providers are notified of this member right on page 210 of the provider handbook.	
Additional Documentation: <ul style="list-style-type: none"> The MCE acknowledged that this information was not included in the hospital contracts nor provider orientation materials. 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526 MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 3-5, section “Right to Inspect/Access PHI”; page 6-8, section “Requests to Amend PHI”. Policy 669.218 Notice of Privacy Practices: page 2-3, section 5(c)-(d). Notice of Privacy Practices: page 1-2. 2024 Member HB English Version_Audit, page 47 	
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220 MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 14, section 1(k). 2024 Member HB English Version_Audit, page 47 	
42 CFR §438.100(c) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 2, section “Policy”; page 14, section 1(l)(iv). 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard II—Member Rights Checklist		
Reference	Required Components	
PIHP Contract: 5.13.1.1.15	<ul style="list-style-type: none"> Policy 669.218 Notice of Privacy Practices: page 3, section A.7. Notice of Privacy Practices: page 2 2024 Member HB English Version_Audit, page 47 	
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	<p>9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA).</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 669.249 Member Rights & Responsibilities: page 13, section “Purpose” A; page 15, section 1(f); page 21, section “Attachment A”. 2024 Member HB English Version_Audit, page 47 	
	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Information Requirements		
<p>1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.</p> <p><i>“Readily accessible” means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.</i></p> <p><i>Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.</i></p> <p style="text-align: right;">42 CFR §438.10(c)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and Procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 159.600 Provider Directory and Online Tools page 7 • 220.100 Member Materials rev 11.2024 pg. 3-4 • ACLA Accessibility Conformance Report (ACR) • 2024 Member HB English Version_Audit pdf • Supporting Evidence – Reading Grade Level of Member Materials • 350.03.TRM.01_Process_for_performing_grade_checks PDF 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> • ACLA Accessibility Conformance Report (ACR), page 2 • PDFs are checked via Adobe Acrobat for accessibility conformance. Corporate Communications utilizes an accessibility scanner, Site improve, which scans PDFs for specific issues. The ACLA website is scanned every three days. 	
MCE Description of Process: ACLA provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. Member facing material undergoes multiple levels of reviews internally and are submitted to LDH for review and approval prior to use.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE uses the definitions for managed care terminology developed by the State including: <ol style="list-style-type: none"> a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, 	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit: Pg. 69-71 • 220.110 Enrollee Handbook Policy Revision 1.2024, pgs 1, 9 Additional Documentation: <ul style="list-style-type: none"> • MMECompanionGuide2022(002), pg22 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary		
MCE Description of Process: ACLA’s Member Handbook is based off the State’s Member Handbook template and includes all required terminology and definitions in the glossary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE uses State-developed model member handbooks and member notices. PIHP: a. <i>The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.</i> 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • ACLA BH-IP MED NEC FULL DENIAL Redacted page 3 • 2024 Member Grievance Acknowledgement Template • 2024 Member HB English Version_Audit: • 220.110 Enrollee Handbook Policy Revision 1.2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> ACLA BH-IP MED NEC FULL DENIAL TEMPLATE_Redacted BH-IP MED NEC FULL DENIAL Member Grievance resolution Template ACLA Admin Partial Denial ACLA Admin Full Denial ACLA CPST Full Denial ACLA Med Nec Full Denial ACLA Med Nec Partial Denial ACLA PDHC ACLA UNTIMELY ACLA CPST Partial Denial 	
<p>MCE Description of Process: ACLA uses an LDH approved Member Handbook and standardized templates as distributed by LDH. Any templates or member facing material developed internally is submitted to LDH for review and approval prior to use.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Language and Format		
<p>4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider directory in English, including taglines Provider directory in prevalent non-English languages, including taglines Member handbook in English, including taglines 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost.</p> <p>b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.</p> <p>c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services.</p> <p>d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE’s member/customer services unit.</p> <p>e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.</p> <p style="text-align: right;">42 CFR §438.10(d)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15</p>	<ul style="list-style-type: none"> Member handbook in prevalent non-English languages, including taglines Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines Definition of conspicuously visible font Mechanisms to ensure taglines are included as part of all critical member materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Copy of denial letter Redacted, pg 5, Multilanguage Interpreter Services; Spanish, Vietnamese; page 6 2024 Non English – Grievance Acknowledgement Letter 2024 English Member Grievance Acknowledgement template Policy 159.600 Provider Directory and Online Tools page 7 20241204 ACLA Online Print Directory.pdf 202141204 ACLA Online Print Directory BH.pdf 220.100 Member Materials rev 11.2024 pg. 3-4 220.110 Enrollee Handbook Policy Revision 1.2024 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Spanish Member HB 2024 <p>Additional Documentation:</p> <ul style="list-style-type: none"> There are tag lines on Pages 8 and 9, in the FAQ section, and last several pages of the Member Handbook which clearly convey that the handbook information is available by other methods, such as on various web pages, by calling Member Services, and by being able to request a large-print version mailed to you. We also have taglines on our web pages and in our non-discrimination notice. 	
<p>MCE Description of Process: ACLA makes written materials critical to obtaining services available electronically in English and Spanish, with a Spanish Member site with downloadable material translated. ACLA does not maintain printed copies of the provider directory in Spanish due to the frequency of required updates but has workflows in place for members to request a printed version. ACLA maintains a contract with a translation and interpretation vendor, and all call center staff are able to use this vendor for member and potential member needs on demand, including any required member notices.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The written materials critical to obtaining services did not meet criteria related to taglines and request for auxiliary aids and services at no cost.</p>		
<p>Required Actions: The MCE must make sure written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in its service areas.</p> <ol style="list-style-type: none"> Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
d. Written materials that are critical to obtaining services include the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number of the MCE’s member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.		
5. The MCE makes interpretation services available to each member free of charge. <ul style="list-style-type: none"> a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. <p style="text-align: right; margin-right: 100px;">42 CFR §438.10(d)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Executed interpretation services (oral and written) contract(s) Workflow for obtaining oral interpretation services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Member Materials_Translation of Materials LSA MSA 20130724 LSA Language List LSA Amendment 14 Updated Pricing <p>Additional Documentation:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit, page 9, under “in other languages and formats”. The verbiage is “at no cost to you.” also included on page 48 under Member Rights and Responsibilities. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA maintains a contract with a translation and interpretation vendor, and all call center staff are able to use this vendor for member and potential member needs on demand</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>6. The MCE notifies members:</p> <p style="margin-left: 20px;">a. That oral interpretation is available for any language and written translation is available in prevalent languages;</p> <p style="margin-left: 20px;">b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and</p> <p style="margin-left: 20px;">c. How to access these services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(d)(5) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit, pg. 9 220.110 Enrollee Handbook Policy Revision 1.2024 pg. 6, 8 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA maintains a contract with a translation and interpretation vendor, and all call center staff are able to use this vendor for member and potential member needs on demand. This information is included in all member-facing material.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE provides all written materials for potential members and members consistent with the following:</p> <p style="margin-left: 20px;">a. Use easily understood language and format.</p> <p style="margin-left: 20px;">b. Use a font size no smaller than 12 point.</p> <p style="margin-left: 20px;">c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member handbook Provider directory All member newsletters during the time period of review Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p><i>“Limited English proficient (LEP)” means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.</i></p> <p style="text-align: right;">42 CFR §438.10(d)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3</p>	<ul style="list-style-type: none"> Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> BH-IP Med Nec Full Denial (Word) pg 3, 5-6 220.100 Member Materials rev 11.2024 pg. 3-4 350.03.TRM.01_Process_for_performing_grade_checks PDF Supporting Evidence – Reading Grade Level of Member Materials 2024 Member HB English Version_Audit Healthy Now Member Newsletter_spring 2024 Healthy Now Member Newsletter Fall 2024_2025 ACLA Med Nec Full Denial (ABD notice) Member Grievance resolution Template (grievance resolution notice) Member grievance template Member Appeal Medical Director Overturn (appeal resolution notice) 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Member Appeal Medical Director Uphold (appeal resolution notice) Language Services Instructions 	
<p>MCE Description of Process: ACLA provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members, including appropriate font size and reading level. Member facing material undergoes multiple levels of reviews internally and are submitted to LDH for review and approval prior to use.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Information for Members		
<p>8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of:</p> <ol style="list-style-type: none"> Thirty calendar days prior to the effective date of the termination; or Fifteen calendar days after receipt or issuance of the termination notice. <p>PAHP:</p> <ol style="list-style-type: none"> The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. <p style="text-align: right;">42 CFR §438.10(f)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.9.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow of provider termination process Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
PAHP Contract: 2.6.11.4 PIHP Contract: 5.14.1.2	<p>(e.g., letter, email) and the notice sent to affected members</p> <ul style="list-style-type: none"> Tracking or reporting mechanism that demonstrates timeliness <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.301 Provider Termination Policy – entire document Provider Initiated Terms – Future Provider Initiated Terms – Past MCE Initiated Terms LDH Exclusions-Recissions List tracking sheet Example of notice to provider uploaded to MCE Initiated Terms folder - Notice to Provider New Decisions Term Letter 01.16.2025 signed certified Example Member Notification Letter – Standard III Element 8 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Examples of termination letter-member letter and provider termination 	
<p>MCE Description of Process: ACLA makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The workflow for terminated providers included a claims history to identify impacted members, assistance to members who need to change their primary care physician, and written notification to members of the provider’s termination.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not support that ACLA made a good faith effort to give written notice, within required time frames, of terminations of a contracted provider to each</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. A member notification letter submitted as evidence was dated 27 days following the LDH-initiated effective date of the provider termination.</p>		
<p>Required Actions: The MCE must ensure it makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided by the later of:</p> <p>a. Thirty calendar days prior to the effective date of the termination; or</p> <p>b. Fifteen calendar days after receipt or issuance of the termination notice.</p>		
<p>9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i).</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of physician incentive plans Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Value Based Program Guide – entire document Value Based Program Guide, slide 31, list of physician incentive plans 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA’s value based guide is published online as Provider Resources, which can be accessed by members and providers. ACLA did not have any requests by members for a physician incentive plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Member Handbook		
<p>10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE:</p> <p>a. Mails a printed copy of the information to the member’s mailing address;</p> <p>b. Provides the information by email after obtaining the member’s agreement to receive the information by email;</p> <p>c. Posts the information on the MCE’s website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or</p> <p>d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information.</p> <p>PAHP:</p> <p>a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled:</p> <p style="margin-left: 20px;">i. A current enrollee handbook</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) Member materials, such as member welcome packet Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Moran Printing SOW LOADED pdf ACLA INT Kits 2024.xlsx 220.110 Enrollee Handbook Policy Revision 1.2024 pdf pg. 8 Welcome Kit – March 2024 ACLA_243391702-1 Roadmap to Health 2024_v01_WEB <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA’s Communication team is working with Corporate Sourcing to update the SOW with the vendor, Moran, that will include the updated process for the welcome kit delivery. 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
MCO Contract: 2.13.6.3 PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2 PIHP Contract: 5.8.3.3	The process is as follows: <ul style="list-style-type: none"> The vendor receives a weekly list of new members through a secure portal from the Enterprise Core Administration (ECA) team. The vendor pulls the list, prepares the mailing, and sends it to new members within 8 business days of receiving the list. The vendor acknowledges completion through the portal once kits are mailed. 	
<p>MCE Description of Process: ACLA includes a Member Roadmap in the Welcome Packet to new members, which includes the option for a member to request and receive a printed Handbook, as well as providing a description for how to access online. We are able to send links to requested member material to their email addresses, when requested, as well as mail printed documents through our print vendor.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Although ACLA provided a written response describing the process followed for delivery of the welcome kit that advised the member of the website location of the member handbook, the provider did not submit written evidence demonstrating the process was in place and operational during the review period. ACLA reported that it is working to update the statement of work with its vendor to include an updated process for welcome kit delivery.</p>		
<p>Required Actions: The MCE must provide the member handbook to members within a reasonable time; acceptable methods include if the MCE:</p> <ol style="list-style-type: none"> a. Mails a printed copy of the information to the member’s mailing address; b. Provides the information by email after obtaining the member’s agreement to receive the information by email; c. Posts the information on the MCE’s website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>11. The member handbook includes all requirements listed in the Member Handbook Checklist.</p> <p style="text-align: right;">42 CFR §438.10(g)(2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on MCE’s website • HSAG will also use the results of the Member Handbook Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit • Link to member handbook on website: https://www.amerihealthcaritasla.com/content/dam/amerihealth-caritas/acla/pdf/member/handbook/english.pdf <p>Additional Documentation:</p> <ul style="list-style-type: none"> • ACLA acknowledges the verbiage in this requirement is not explicitly included in the Member Handbook. 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA’s Member Handbook is compliant with the Member Handbook Checklist.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s member handbook did not include information regarding 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.</p>		
<p>Required Actions: The MCE must include information in the member handbook regarding 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.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change.</p> <p><i>Note: LA defines significant as “important in effect or meaning.”</i></p> <p style="text-align: right;">42 CFR §438.10(g) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow for member handbook changes One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the <i>MCE Description of Process</i>) Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Follow Up – MCO Handbooks and PBM Updates pdf ACLA Medicaid-Welcome Kit Insert (from 2023 change to single PBM) MORAN Printing SOW Loaded pg 5 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: There were no changes that could be deemed “significant” during 2024, but we have included documentation from 2023 related to the transition to the Single PBM.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Provider Directory		
<p>13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist.</p> <p style="text-align: right;">42 CFR §438.10(h)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) Link to the online provider directory HSAG will also use the results of the Provider Directory Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools pages 3&4 20241204 ACLA Online Print Directory.pdf 20241204 ACLA Online Print Directory BH.pdf Link to the online provider directory: https://amerihealthcaritasla.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACLA_I&brandCode=ACLA&alphaPrefix=&bcbSaProductId=&productCode=2100 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Find A Provider Website 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	Note: We have our “Find a Provider” tool that is on our Member tab on the website. Within that tab, members can search for a variety of PCPs and specialists. This is also located on our Maternity Care Center on the website.	
<p>MCE Description of Process: ACLA makes the provider directory available in paper form upon request and electronic form. The provider directory includes the information from the Provider Directory checklist.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s paper provider directory did not include the following components:</p> <ul style="list-style-type: none"> • Website Uniform Resource Locator (URL) • Whether the provider will accept new members • Youth residential provider type <p>ACLA’s electronic provider directory did not include the following components:</p> <ul style="list-style-type: none"> • Youth residential provider type <p>Recommendations: HSAG recommends that the MCE ensure its public, searchable provider directory is updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p>Required Actions: The MCE must include the following components in the paper provider directory:</p> <ul style="list-style-type: none"> • Website URL • Whether the provider will accept new members • Youth residential provider type <p>The MCE must include the following components in the electronic provider directory:</p> <ul style="list-style-type: none"> • Youth residential provider type 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>14. Information included in the MCE’s paper provider directory is updated at least:</p> <p style="margin-left: 20px;">a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or</p> <p style="margin-left: 20px;">b. Quarterly, if the MCE has a mobile-enabled electronic provider directory.</p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.10(h)(3)(i) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Verification of a mobile-enabled electronic provider directory Workflow for updating paper provider directories Three consecutive provider directory update examples, including the dates for when the updates were made <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 4 Mobile Enabled via Website Provider Directory Update Examples uploaded and located in the following folders: <ul style="list-style-type: none"> – Directory Update Example 1 – Directory Update Example 2 – Directory Update Example 3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA complies with contract requirements for timely dating of the provider directory.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. Information included in the MCE’s electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow for updating the electronic provider directory 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>MCO: a. The web-based online version shall be updated in real time, but no less than weekly.</p> <p>PAHP: a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly.</p> <p style="text-align: right;">42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3</p>	<ul style="list-style-type: none"> Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated provider information and the date the change was reflected in the electronic provider directory Tracking mechanisms to demonstrate timeliness <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 4 Provider Directory Update Examples uploaded and located in the following folders: Directory Update Example 1 Directory Update Example 2 Directory Update Example 3 	
<p>MCE Description of Process: ACLA complies with contractual requirements related to the online directory, including web-based searchable, readable and mobile enabled.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>16. The MCE’s provider directory is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right;">42 CFR §438.10(h)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Confirmation of machine-readable provider directory (e.g., .JSON format) Link to the publicly available machine-readable provider directory on the MCE’s website 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> 159,600 Provider Directory and Online Tools, page 7 Machine-Readable File and Format Link to the publicly available machine-readable provider directory: https://amerihealthcaritasla.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACLA_I&brandCode=ACLA&alphaPrefix=&bcbsaProductId=&productCode=2100/machine-readable 	
MCE Description of Process: ACLA’s provider directory is available on the public facing website, accessible without any security restrictions and is compliant with the machine-readable requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Formulary		
17. The MCE makes available in electronic or paper form the following information about its formulary: <ol style="list-style-type: none"> Which medications are covered (both generic and name brand). What tier each medication is on. <div style="text-align: right; margin-top: 10px;"> 42 CFR §438.10(i)(1-2) 42 CFR §457.1207 </div> <div style="margin-top: 10px;"> MCO Contract: NA PAHP Contract: NA PIHP Contract: NA </div>	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Copy of formulary in Word or PDF format (excerpts are acceptable) Link to the publicly available formulary on the MCE’s website 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Formulary items 17 and 18 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf Louisiana Medicaid Preferred Drug List (PDL) https://www.amerihhealthcaritasla.com/pharmacy/formulary 	
<p>MCE Description of Process: ACLA must follow LDH’s formulary and ACLA’s website points directly to LDH. The information on this link can be downloaded as needed.</p>		
<p>HSAG Findings: The State contracted with a single Pharmacy Benefits Manager (PBM) for the Louisiana Medicaid managed care program; therefore, HSAG has determined that this requirement is not applicable. However, the MCE did provide a link on its website to a formulary that the single PBM maintained.</p>		
<p>Required Actions: No action required.</p>		
<p>18. The MCE’s formulary drug list is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right;">42 CFR §438.10(i)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Confirmation of machine-readable formulary (e.g., .JSON format) Link to the publicly available machine-readable formulary on the MCE’s website <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Formulary items 17 and 18 https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf Louisiana Medicaid Preferred Drug List (PDL) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA must follow LDH’s formulary and ACLA’s website points directly to LDH. The information on this link can be downloaded as needed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
Electronic Materials and Communications		
<p>19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following:</p> <ol style="list-style-type: none"> a. The format is readily accessible. b. The information is placed in a location on the MCE’s website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. <p style="text-align: right;">42 CFR §438.10(c)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE’s homepage of its website • Tracking mechanisms related to requests for information in paper form that includes the date of the member’s request and the date it was provided to the member (e.g., mailed) • Evidence for how members are informed that paper copies of information are available upon request and without charge <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • www.amerihhealthcaritasla.com • Member Materials, Translation of Materials, entire document • 2024 Member HB English Version_Audit, pages 15, 29, 76 • Member Materials Translation of Materials Welcome Outreach (1) 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA’s website does not have any security restrictions and can be accessed by members and providers without restriction. There are no member materials that are only available electronically and all information is consistent with federal requirements. ACLA does not impose any charges to members for requesting printed documents, as evidenced in the Member Handbook.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not verify compliance because ACLA’s website did not include language informing the members that information that is available in electronic form is available in paper form without charge upon request and that the MCE will provide it upon request within five business days. In addition, a PDF accessibility checker was used to evaluate the member handbook posted on ACLA’s website, and the results indicated that the logical reading order required manual verification.</p>		
<p>Required Actions: The MCE must ensure member information, provided electronically, is readily accessible and that the member is informed that the information is available in paper form without charge upon request and that the MCE will provide it upon request within five business days.</p>		

Results for Standard III—Member Information							
Total	Met	=	12	X	1	=	12
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	18	Total Score		=	12

Total Score ÷ Total Applicable	=	67%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference	Required Components	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit – Benefits and Services pg. 11-14 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit – Benefits and Services, pages 42-43 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit – Transportation pg. 21 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> AmeriHealth Caritas Louisiana does not determine benefits or coverage based on any moral or religious reason. This information can be found on pg. 11 of the 2024 Member HB English Version_Audit 	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207	<p>5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections.</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> AmeriHealth Caritas Louisiana does not determine benefits or coverage based on any moral or religious reason. This information can be found on pg. 11 of the 2024 Member HB English Version_Audit 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4		
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207	<p>6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. <i>For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services pg. 11-12 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10		
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207	<p>7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. <i>The PIHP must also include procedures for plan of care development.</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Prior Authorization Process – pg 41-42 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11		
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207	<p>8. The extent to which, and how, after-hours care is provided.</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services pg 17 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.1		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14		
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207	9. What constitutes an emergency medical condition and emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services pg. 17-18, 69 	
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207	10. The fact that prior authorization is not required for emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Prior Authorization pg 41-42 	
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207	11. The fact that the member has a right to use any hospital or other setting for emergency care.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services, pg. 42 	
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207	12. Any restrictions on the member’s freedom of choice among network providers.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services pg. 16 	
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.10		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
PAHP Contract: 2.9.7.2 PIHP Contract: None	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Family Planning Services pg. 29 	
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan). Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Copays, pg 23 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Rights and Responsibilities pg. 47-49 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member’s primary care provider/primacy dental provider. Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Benefits and Services pg. 15 2024 Member HB English Version_Audit – Changing your primary care provider (PCP) pg. 58 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	17. The right to file grievances and appeals. Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Grievances, Appeals, and Fair Hearings pg. 53 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Grievances, Appeals, and Fair Hearings pg. 53-55 	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	19. The availability of assistance in the filing process for grievances and appeals.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Grievances, Appeals, and Fair Hearings pg. 53 	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	20. The right to request a state fair hearing (SFH) (or a State external review for the Children’s Health Insurance Program [CHIP]) after the MCE has made a determination on a member's appeal which is adverse to the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Grievances, Appeals, and Fair Hearings pg. 56 	
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Member Grievances, Appeals, and Fair Hearings pg. 56 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) <i>The MCOs must provide a description of advance directives which includes:</i> <i>The MCO’s policies related to advance directives;</i> <i>The enrollee’s rights under State Law, including the 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 2024 Member HB English Version Audit as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;</i> <i>Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana’s Survey and Certification agency; and</i> <i>Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit – Advance Directives – pg. 52 	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5; 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. <i>For the MCO, this instruction shall be included in all versions of the 2024 Member HB English Version Audit in English and Spanish.</i> <i>For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 2024 Member HB English Version_Audit – Getting Started, In other languages and formats – pg. 9 • Spanish 2024 Member HB English Version_Audit - Otros idiomas y formatos – pg. 9 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – 6, 13-14, 18, 21, 22, 27, 35, 38, 39, 41, 68 	
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Fraud, Waste, and Abuse – pg. 56 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. <i>The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Getting Started – pg. 10 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	27. <i>The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – How You Can Help Us – pg. 7 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. <i>The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – How You Can Help Us – pg. 7, 17, 50 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.28 PAHP Contract: NA PIHP Contract: NA	29. <i>The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Other Sources of Payment pg. 45 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	30. <i>The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – If you have other health insurance- pg. 45 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. <i>The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – How You Can Help Us, pg. 7 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. <i>The MCOs must include the date of the last revision;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 2024 Member HB English Version_Audit – Back cover, Revision Date, page 78 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA	33. <i>The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:</i> <ol style="list-style-type: none"> a. <i>A description of covered behavioral health services;</i> b. <i>Where and how to access behavioral health services and behavioral health providers;</i> 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
PIHP Contract: NA	<p>c. <i>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;</i></p> <p>d. <i>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</i></p> <p>e. <i>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.</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit, Benefits and Services pg. 25-29 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	<p>34. <i>The PIHP must include CSoC eligibility requirements;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A to MCO 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	<p>35. <i>The PIHP must include Member’s Bill of Rights;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A to MCO 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	<p>36. <i>The PIHP must include where to find medical necessity criteria on the Contractor’s website and how to request hardcopies of medical necessity criteria;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A to MCO 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	37. <i>The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a “no-show;”</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. <i>The PIHP must include family’s/caregiver’s or legal guardian’s role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. <i>The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult’s engagement, resilience, strength-based and evidence-based practice, and best/proven practices;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. <i>The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. <i>The PIHP must include 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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. <i>The PIHP must include how to identify and contact the WAAs and FSO;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. <i>The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. <i>The PIHP must include the date of the last revision;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. <i>The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A to MCO 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA	46. <i>The PIHP must include additional information that is available upon request, including the following:</i> <ol style="list-style-type: none"> a. <i>Information on the structure and operation of the Contractor;</i> b. <i>Pharmacy location or medication information availability;</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Member Handbook Checklist		
Reference	Required Components	
PAHP Contract: NA PIHP Contract: 5.9.2.35	c. <i>Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and</i> d. <i>Service utilization policies</i>	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A to MCO 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Provider Directory Checklist

Standard III—Provider Directory Checklist		
Reference	Required Components	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider’s name as well as any group affiliation.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	4. Website Uniform Resource Locator (URL), as appropriate.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Provider Directory Checklist		
Reference	Required Components	
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	7. The provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider’s office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 159.600 Provider Directory and Online Tools page 3 	
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1	9. The MCE provider directory components are included for the following provider types:	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	a. Physicians, including specialists; b. Hospitals; c. Pharmacies;	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Provider Directory Checklist	
Reference	Required Components
PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	<p>d. Behavioral health providers;</p> <p>The MCO provider directory components are included for the following provider types <i>and shall be delineated by parish and zip code</i>:</p> <ul style="list-style-type: none"> a. <i>Hospital primary care physician (PCP) groups</i> b. <i>Clinic settings</i> c. <i>Home and community-based services</i> d. <i>Outpatient therapy</i> e. <i>Residential substance use</i> f. <i>Youth residential services</i> g. <i>Inpatient mental health and residential substance use services</i> h. <i>Federally qualified health centers (FQHCs)</i> i. <i>Rural health clinics (RHCs)</i> j. <i>Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.</i> k. <i>Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.</i> l. <i>Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.</i> <p>The PAHP provider directory components are included for the following provider types:</p> <ul style="list-style-type: none"> a. <i>Endodontists</i> b. <i>Maxillofacial surgeons</i> c. <i>Oral surgeons</i> d. <i>Orthodontists</i> e. <i>Pedodontists</i> f. <i>Periodontists</i> g. <i>Prosthodontists</i> h. <i>Special needs pedodontists</i> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 159.600 Provider Directory and Online Tools page 3



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard III—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	10. <i>The PAHP provider directory must include the following:</i> <ol style="list-style-type: none"> a. <i>The provider’s cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;</i> b. <i>Office hours;</i> c. <i>Specific performance indicators;</i> d. <i>A statement that some providers may choose not to perform certain services based on religious or moral beliefs;</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE:	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. <i>The PAHP Provider Directory must also include the following:</i> <ol style="list-style-type: none"> a. <i>Providers arranged by name in alphabetical order</i> b. <i>Showing the provider’s specialty,</i> c. <i>Providers listed by specialty in alphabetical order by name.</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE:	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. <i>The PIHP Provider Directory must include the following:</i> <ol style="list-style-type: none"> a. <i>Indication of populations served by the provider (e.g., age range of clients) and specialties;</i> b. <i>Identification of any restrictions on the member’s freedom of choice among providers;</i> c. <i>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);</i> d. <i>Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE:	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Definitions		
<p>1. The MCE defines “emergency medical condition” as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ol style="list-style-type: none"> a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.001 Glossary of Terms, pages 8 &19 ACLA Provider Handbook for December 2024, pages 88-89 2024 Member HB English Version_Audit, page 69 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA complies with the prudent layperson standard to define emergency medical conditions and does not impose any restrictions on diagnoses or health conditions when adjudicating claims for emergency services nor conduct post service reviews for medical necessity.</p>		
<p>UM does not re [MCE submission left as submitted]</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>2. The MCE defines “emergency services” as covered inpatient and outpatient services that are as follows:</p> <p style="margin-left: 20px;">a. Furnished by a provider that is qualified to furnish these services under Title 42.</p> <p style="margin-left: 20px;">b. Needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.001 Glossary of Terms, page 19 ACLA Provider Handbook for December 2024, page 64 2024 Member HB English Version_Audit, page 69 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA’s utilization management and claims adjudication processes are aligned with the MCO Contract definition of emergency services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE defines “poststabilization care services” as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.001 Glossary of Terms, page 13 ACLA Provider Handbook for December 2024, page 64 2024 Member HB English Version_Audit, page 11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCE Description of Process: ACLA’s utilization management and claims adjudication processes are aligned with the MCO Contract definition of poststabilization care services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment		
<p>4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE.</p> <p style="text-align: right;">42 CFR §438.114(c)(1)(i) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024 , page 64 2024 Member HB English Version_Audit, page 11 ACLA Claim Filing Updates for December 2024 – FINAL,page 126 (algorithm) Claim Example, Elements 4, 5, 6, 7 UM.905 Emergency Room Services, pages 2 – 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA reimburses emergency services for both in-network and out-of-network providers when billed with revenue code 450 or 459 along with the appropriate CPT code of 99281-99285 or 99291.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE does not deny payment for treatment obtained under either of the following circumstances:</p> <p style="margin-left: 20px;">a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of “emergency medical condition.”</p> <p style="margin-left: 20px;">b. A representative of the MCE instructs the member to seek emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual Claim payment algorithm for emergency services Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024, pages 64 and 88 Claim Example, Elements 4, 5, 6, 7 ACLA Claim Filing Updates for December 2024 – FINAL, page 126 2024 Member HB English Version_Audit, page 11 UM.905 Emergency Room Services, page 1 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCE Description of Process: ACLA is financially responsible for emergency services for both in-network and out-of-network providers without authorization requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Additional Rules for Emergency Services		
<p>6. The MCE does not:</p> <p style="margin-left: 20px;">a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.</p> <p style="margin-left: 20px;">b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the MCE, or applicable State entity of the member’s screening and treatment within 10 calendar days of presentation for emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(d)(1) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual Claim payment algorithm for emergency services Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024, page 88 Claim Example, elements 4, 5, 6, 7 ACLA Claim Filing Updates for December 2024 – FINAL, page 126 2024 Member HB English Version_Audit, page 11 & 18 UM.905 Emergency Room Services, page 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA’s utilization management and claims adjudication processes are aligned with these contract requirements and do not impose any restrictions on the definition of emergency medical service (prudent layperson standard). ACLA does not deny payment for emergency services based on a lack of notification of such emergency medical care to the member’s PCP.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that ACLA include the federal language “or applicable State entity of the member’s screening and treatment within 10 calendar days of presentation for emergency services” to the Provider Handbook and Hospital Agreement template.</p>		
<p>Required Actions: No action required.</p>		
<p>7. 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 member.</p> <p style="text-align: right;">42 CFR §438.114(d)(2) 42 CFR §457.1228</p> <p>MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL, page 64 • Claim Example, elements 4, 5, 6, 7 • ACLA Claim Filing Updates for December 2024 – FINAL, page 126 • 2024 Member HB English Version_Audit, page 23 • UM.905 Emergency Room Services, page 2 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA will not hold the member liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>8. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE.</p> <p style="text-align: right;">42 CFR §438.114(d)(3) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL, page 64 • UM.905 Emergency Room Services, page 8 		
<p>MCE Description of Process: ACLA’s Utilization Management (UM) department does not review any emergency services and those pay without authorization. There are no peer-to-peer examples as we would not have denials (or approvals) in our system.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Coverage and Payment of Poststabilization Care Services		
<p>9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(i)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for post stabilization services 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1	<ul style="list-style-type: none"> Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) 	
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL, page 64 Online Help Resources_ Post Stabilization claim review process Emergency and Poststabilization Services Claim Example, Element 9 	
MCE Description of Process: ACLA adjudicates emergency claims for post stabilization services for both in-network and out-of-network providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Recommendations: HSAG recommends that ACLA create a workflow that outlines the claims review process for poststabilization services.		
Required Actions: No action required.		
10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member’s stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.1	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual Workflow for claims review process for poststabilization services 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL, page 64-65 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1	<ul style="list-style-type: none"> Online Help Resources_ Post Stabilization claim review process UM.905 Emergency Room Services, page 2 	
MCE Description of Process: ACLA is responsible for post stabilization services for both in-network and out-of-network providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Recommendations: HSAG recommends that ACLA create a workflow that outlines the claims review process for poststabilization services.		
Required Actions: No action required.		
<p>11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member’s stabilized condition if:</p> <ol style="list-style-type: none"> The MCE does not respond to a request for pre-approval within one hour. The MCE cannot be contacted. The MCE representative and the treating physician cannot reach an agreement concerning the member’s care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. <p style="text-align: right;">42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual Workflow for claims review process for poststabilization services Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE’s response One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL page 64-65 Online Help Resources_ Post Stabilization claim review process Element 11 Peer-to-Peer example UM.905 Emergency Room Services, page 2 BITS Screenshot 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1		
MCE Description of Process: ACLA reimburses poststabilization services for in-network and out-of-network when billed according to standard coding guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Recommendations: HSAG recommends that ACLA create a workflow that outlines the claims review process for poststabilization services.		
Required Actions: No action required.		
<p>12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Workflow for claims review process for poststabilization services Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA Hospital Services Agreement, page 18, Section 9.10(i) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
End of the MCE’s Financial Responsibility		
<p>13. The MCE’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ul style="list-style-type: none"> a. A plan physician with privileges at the treating hospital assumes responsibility for the member’s care. b. A plan physician assumes responsibility for the member’s care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member’s care. d. The member is discharged. <p style="text-align: right; margin-right: 50px;">42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL, page 65 • UM.905 Emergency Room Services, page 13 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: ACLA requires medical necessity review for poststabilization services as indicated by requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Results for Standard IV—Emergency and Poststabilization Services						
Total	Met	=	13	X	1	= 13
	Not Met	=	0	X	0	= 0
	Not Applicable	=	0			
Total Applicable		=	13	Total Score	=	13

Total Score ÷ Total Applicable	=	100%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
Delivery Network		
<p>1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(b)(1) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Analysis of provider network linguistic capabilities Analysis of provider network capabilities to serve members with special health care needs Provider materials, such as the provider manual One example of each type of provider contract (ancillary, hospital, and individual/group) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Ancillary-Srvs_Agmt (08-01-2022) ACLA Hospital_Srvs_Agmt (08-01-2022) ACLA PCP_Srvs_Agmt (08-01-2022) ACLA Specialist_Srvs_Agmt (08-01-2022) 159.201 Provider Accessibility and Availability Standards page 5 2024 Availability of Practitioners Report ACLA Provider Handbook for December 2024-FINAL, page 20, 35, 188 AIM Physical Therapy (specialty) Bridgepoint Continuing Care Hospital (hospital) 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Family Healthcare Solutions (individual PCP) Oak Haven Healthcare Center (ancillary) 2024 LA REL Provider Reports <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provider Network-Special Needs 	
<p>MCE Description of Process: ACLA maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s provider agreement demonstrated that the plan had written agreements with providers. ACLA’s Provider Accessibility and Availability Standards policy outlined ACLA’s commitment to require providers to provide “services in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.” ACLA’s 2024 Availability of Practitioners Report provided an analysis of ACLA’s provider network’s linguistic capabilities. Additionally, ACLA’s 2024 LA REL Provider Reports demonstrated ACLA’s tracking of spoken languages by providers during its credentialing and recredentialing processes. ACLA subsequently submitted a Provider Network-Special Needs directory listing that was generated August 21, 2025, which was outside the review period and was not considered for this review.</p>		
<p>Required Actions: The MCE must monitor its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p>		
<p>2. The MCE provides female members with direct access to a women’s health specialist within the provider network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health specialist.</p> <p style="text-align: right;">42 CFR §438.206(b)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Coverage/authorization guidelines <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.003 Standard and Expedited Prior Authorization of Services pg 2,policy section; 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
PAHP Contract: NA PIHP Contract: NA	page 16- ACLA Services Not Requiring Prior Authorization/Notification/Referral <ul style="list-style-type: none"> 2024 ACLA Utilization Management Program Description, page 15 (Referral) ACLA Provider Handbook for December 2024-FINAL page 108 159.201 Provider Accessibility and Availability Standards, pages 3, 8 2024 Member HB English Version_Audit: pg. 19 and 29 UM.401 Direct Access to Providers, page 1 	
<p>MCE Description of Process: ACLA provides female members with direct access to a women’s health specialist within the provider network for covered care necessary to provide women’s routine and preventive health care services. This information is outlined in policies and provider and member handbooks.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. <div style="text-align: right;">42 CFR §438.206(b)(7) 42 CFR §457.1230(a)</div> MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook List of provider types designated as family planning providers Network adequacy analysis of family planning providers 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL page 67-68 • 159.201 Provider Accessibility and Availability Standards pages 4, 8 • 2024 Member HB English Version_Audit: pg. 29 • 220 ACLA 2024 SA1 Revised 1 • 220 ACLA 2024 SA2 	
MCE Description of Process: ACLA has no restrictions on provider types who can provide family planning services, ensuring timely access to covered services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. <div style="text-align: right;">42 CFR §438.206(b)(3) 42 CFR §457.1230(a)</div> MCO Contract: 2.13.6.2.32 PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5 PIHP Contract: 7.2.8	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • UM.404 Access to a Second Opinion page 1, policy section • 2024 Member HB English Version_Audit, pg 20 Additional Documentation: <ul style="list-style-type: none"> • Compliance Overview 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> UM Timeliness Report 2024_Medical Behavioral Health Copy of JIVA_59_Aging_Report_20240123 UM.404 Access to Second Opinion Policy, Pages 1, 2 	
<p>MCE Description of Process: ACLA has no restrictions on members’ right to obtain second opinions and will cover the cost of such. Accordingly, there is no tracking mechanism.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them.</p> <p style="text-align: right;">42 CFR §438.206(b)(4) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Network adequacy monitoring mechanisms Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 159.202 Provider Availability Standards Analysis page 7 2024 Member HB English Version_Audit, pg 21 SCA Examples (Eunice Community Home Health, Infusion Partners-Carepoint Partners, Lakeshore Manor Nursing & Rehab LLC) 346 ACLA 2024 Q1 Resubmit 1 346 ACLA 2024 Q2 Replace 1 346 ACLA 2024 Q3 346 ACLA 2024 Q4 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: If ACLA is unable to provide necessary services to a particular member, ACLA will initiate a Single Case Agreement with an out of network provider for the member to receive services as needed. ACLA will make every effort to contract that provider or ensure that a provider in the area is contracted to provide those services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p style="text-align: right;">42 CFR §438.206(b)(5) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Claims processing guidelines Member materials, such as the member handbook Provider materials, such as materials on the MCE’s website Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.904 Prior Authorization of Non-Participating Providers page 2 SCA letter template_Medicaid, page 1 SCA Examples (Eunice Community Home Health, Infusion Partners-Carepoint Partners, Lakeshore Manor Nursing & Rehab LLC) 2024 Member HB English Version_Audit, pg 21 https://www.amerihhealthcaritasla.com/provider/non-contracted-providers 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Through Single Case Agreements, ACLA requires out-of-network providers to coordinate with ACLA for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<i>42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]</i>		
Timely Access		
<p>7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • HSAG will also use the results of the Access Standards: Appointment Times Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 159.202 Provider Availability Standards Analysis page 1 • ACLA Ancillary-Srvs_Agmt (08-01-2022), page 17 • ACLA Hospital_Srvs_Agmt (08-01-2022), page 19 • ACLA PCP_Srvs_Agmt (08-01-2022), page 16 • ACLA Specialist_Srvs_Agmt (08-01-2022), page 17 • ACLA Provider Handbook for December 2024-FINAL , page 23, 30, 197 • 2024 Availability of Practitioners Report 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Q1 2024 BH Secret Shopper Detail Q2 2024 BH Secret Shopper Detail 	
<p>MCE Description of Process: ACLA meets all timely access to care standards and requires its network providers to meet timely access to care standards. Standards are detailed in policies and Provider Handbook and are routinely assessed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s Policy 159.202 Provider Availability Standards Analysis outlined ACLA’s commitment to monitor and maintain a provider network sufficient to provide adequate access to all services covered under the contract for all members. Specifically, ACLA’s 159.202 Provider Availability Standards Analysis policy stated that ACLA monitors its network by analyzing geographic distribution and geo access reports. ACLA’s 2024 Availability of Practitioners Report and 2024 Behavioral Health Secret Shopper Detail reports analyzed ACLA’s provider network according to time/distance and member-to-provider ratio standards, but not according to appointment availability standards. ACLA’s Appointment Times Checklist and the accompanying evidence were also used by the HSAG reviewer to evaluate this requirement, which found that most providers met the 90 percent goal for appointment times except for Primary Care Physicians (PCPs) concerning Urgent Non-Emergency Care (88 percent); PCPs and Pediatricians concerning After-Hours Access (56 percent); Behavioral Health Prescribers concerning Non-Life Threatening Emergent Care (81 percent) and Initial Visit Routine Care (77 percent); Behavioral Health Non-Prescribers concerning Non-Life Threatening Emergent Care (81 percent); and OB/GYNs concerning first trimester (88 percent), second trimester (46 percent), third trimester (62 percent), high risk (76 percent), and waiting room wait time (81 percent).</p>		
<p>Required Actions: The MCE must require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.</p>		
<p>8. MCO: The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members. PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. 42 CFR §438.206(c)(1)(ii)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Audit or secret shopper results/reports <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL pg 30 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA</p>	<ul style="list-style-type: none"> 159.201 Provider Accessibility and Availability Standards, page 11 2024 Availability of Practitioners Report Q1 2024 BH Secret Shopper Detail Q2 2024 BH Secret Shopper Detail <p>Additional Documentation:</p> <ul style="list-style-type: none"> 159.201 Provider Accessibility and Availability Standards, page 9 ACLA Primary Care Provider Agreement, page 4 	
<p>MCE Description of Process: ACLA ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. This is routinely assessed and outlined in our provider handbook and policies.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA provided evidence but none stated that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. In its subsequent submission, ACLA provided the ACLA Primary Care Provider Agreement, which stated that providers must “provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by ACLA.” Additionally, ACLA provided a subsequent citation in its 159.201 Provider Accessibility and Availability Standards policy concerning “Mainstreaming,” which provided “examples of prohibited practices” that included 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.” ACLA’s initial and subsequent submissions did not include audit or secret shopper results/reports ensuring that its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS if the provider serves only Medicaid members.</p>		
<p>Required Actions: The MCE must ensure, through monitoring and data analysis, that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS if the provider serves only Medicaid members.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Results of provider monitoring mechanisms Audit or secret shopper results/reports <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL pages 23, 197 159.201 Provider Accessibility and Availability Standards, pages 3, 7, 8-9 2024 Availability of Practitioners Report Q1 2024 BH Secret Shopper Detail Q2 2024 BH Secret Shopper Detail ACLA Specialist Srvs_Agmt, page 25 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. This is routinely assessed and outlined in our provider handbook and policies.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers.</p> <p>a. The MCE monitors network providers regularly to determine compliance.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Results of provider monitoring mechanisms Audit or secret shopper results/reports Three examples of corrective action taken when a provider fails to meet timely access standards 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>b. The MCE takes corrective action if there is a failure to comply by a network provider.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.202 Provider Availability Standards Analysis, pgs 9, 10-11 2024 Availability of Practitioners Report Q1 2024 BH Secret Shopper Detail Q2 2024 BH Secret Shopper Detail 	
<p>MCE Description of Process: ACLA has established mechanisms to ensure compliance with timely access to care and services standards by routine assessments and educating providers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Access and Cultural Considerations		
<p>11. The MCE participates in the State’s efforts to promote the delivery of 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 sex.</p> <p style="text-align: right;">42 CFR §438.206(c)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Cultural competency plan Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory Analysis of provider network linguistic capabilities Analysis of provider network cultural competence <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.201 Provider Accessibility and Availability Standards page 7 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Uploaded Provider Health Equity Training ACLA Provider Handbook for December 2024-FINAL page 33 ACLA Ancillary-Srvs_Agmt (08-01-2022), page 11, 17 ACLA Hospital_Srvs_Agmt (08-01-2022), pages 18-19 ACLA PCP_Srvs_Agmt (08-01-2022), page 19 ACLA Specialist_Srvs_Agmt (08-01-2022), page 17 2024 LA REL Provider Reports 2024 Health Equity Provider Training Final 2024 Q1 HECLAS Updates QSC 2024 Q2 HECLAS Updates QSC 2024 Q3 HECLAS Updates QSC 2024 Q4 HECLAS Updates QSC <p>Additional Documentation:</p> <ul style="list-style-type: none"> Requirement 11, Directory Requirement 11, Directory Examples 	
<p>MCE Description of Process: ACLA routinely conducts Health Equity training and information and ensure information is available to our providers via the provider handbook, policies and is included in all provider agreements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
Accessibility Considerations		
<p>12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(c)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers’ accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA Ancillary-Srvs_Agmt (08-01-2022), page 17 • ACLA Hospital_Srvs_Agmt (08-01-2022), page 18 • ACLA PCP_Srvs_Agmt (08-01-2022), page 16 • ACLA Specialist_Srvs_Agmt (08-01-2022), page 16 • ACLA Provider Handbook for December 2024-FINAL pages 28 - 29, 33 • Provider ADA Accessibility 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Site Survey Form ACLA Site Visit Tool Template Site Survey – The Virginia House <p>Additional Documentation:</p> <ul style="list-style-type: none"> Requirement 12, Directory Network Requirement 12, Directory Screen Shot Requirement 12, Directory 	
<p>MCE Description of Process: ACLA ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities by educating via the provider handbook, site surveys, and is included in all network provider agreements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s provider directory and provider agreements stated that its network providers must provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. ACLA also provided Provider Directory screenshots that included the following accommodations for members with physical or mental disabilities: Blind/Visually Impaired, Cognitively Disabled, Americans with Disabilities Act (ADA)—Compliance Access Service Location, ADA—Compliant Restrooms, ADA—Compliant Exam Rooms, Deaf or Hard of Hearing, Handicap Accessible Medical Equipment, ADA—Compliant Parking, ADA—Compliant Building Access, ADA—Compliant Public Access, ADA-Compliant Office Access. ACLA’s Site Survey Form and Site Visit Tool Template demonstrated monitoring of its provider network accessibility accommodations, but did not provide an analysis of provider network capability to provide services to members with physical or mental disabilities.</p>		
<p>Required Actions: The MCE must ensure, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p>		
Basic Rule		
<p>13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Network adequacy reports/analyses 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>in accordance with the State’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).</p> <p>a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:</p> <p style="margin-left: 20px;">i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area.</p> <p style="margin-left: 20px;">ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p> <p>PIHP</p> <p>a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population).</p> <p style="margin-left: 100px;">42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2</p>	<ul style="list-style-type: none"> Exceptions approved by the State HSAG will also use the results of the Access Standards: Time/Distance Checklist HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 220 ACLA 2024 SA1 Revised 1 220 ACLA 2024 SA2 338 ACLA 2024 Q4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> 2024 Report Submission Timeliness Report 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA submits geographic access reports for physical health and behavioral health on a quarterly and semi-annual basis that demonstrates our capacity to serve the expected enrollment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s 159.201 Provider Accessibility and Availability Standards and 159.202 Provider Availability Standards Analysis policies outlined the accessibility standards as well as ACLA’s procedure for monitoring its network providers’ compliance with these standards. The HSAG reviewer also reviewed the Time/Distance and Member-to-Provider Ratio checklists, and areas of noncompliance were identified. In its subsequent submission, ACLA provided a 2024 Report Submission Timeliness Report, and upon review, the HSAG reviewer identified that ACLA submitted its network adequacy reports to the State on time or ahead of the deadline for the entire review period. Furthermore, ACLA staff members stated that ACLA did not request any exceptions from the State.</p>		
<p>Required Actions: The MCE must ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p>		
Timing		
<p>14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following:</p> <ol style="list-style-type: none"> a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE’s operations that would affect the adequacy of capacity in services, including: <ol style="list-style-type: none"> i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. <p style="text-align: right; margin-right: 50px;">42 CFR §438.207(c) 42 CFR §457.1230(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 220 ACLA 2024 SA1 Revised 1 • 220 ACLA 2024 SA2 • 338 ACLA 2024 Q4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2024 Report Submission Timeliness Report 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2		
MCE Description of Process: ACLA submits geographic access reports for physical health and behavioral health on a quarterly and semi-annual that demonstrates our capacity to serve the expected enrollment. There has been no significant change in the MCE’s operations that would affect the adequacy of capacity in services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Exceptions Process		
<p>15. To the extent the State permits an exception to any of the provider-specific network standards,</p> <p>MCO:</p> <p>a. <i>The MCO must submit any requests for exceptions for distance or appointment access for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.</i></p> <p>PAHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.</i></p> <p>PIHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.</i></p> <p style="text-align: right;">42 CFR §438.68(d)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
42 CFR §438.207 42 CFR §457.1230(b) MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3		
MCE Description of Process: ACLA submits geographic access reports for physical health and behavioral health on a quarterly and semi-annual that demonstrates our capacity to serve the expected enrollment. There has been no need to submit any requests for exceptions for distance or appointment accessibility standards.		
HSAG Findings: The MCE confirmed that it did not submit any requests for exceptions to the State in 2024; therefore, HSAG has determined that this element is not applicable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	9	X	1	=	9
	Not Met	=	5	X	0	=	0
	Not Applicable	=	1				
Total Applicable	=	14	Total Score	=	9		

Total Score ÷ Total Applicable	=	64%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
Primary Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. <i>MCO:</i> a. <i>PCP appointments are available as follows:</i> i. <i>Non-urgent sick primary care: 72 hours</i> ii. <i>Non-urgent routine primary care: 6 weeks</i> <i>PAHP:</i> a. <i>Primary dental care: within 30 days</i> b. <i>Follow-up dental services: within 30 days after assessment</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
Evidence as submitted by the MCE: <ul style="list-style-type: none"> BH Access and Availability Survey Q2 2024 2024 ACLA BH_PH Access and Availability Survey 		
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. <i>MCO:</i> a. <i>For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide:</i> b. <i>Specialist appointments: one month</i> c. <i>Non-urgent routine behavioral health care: 14 days</i> d. <i>Urgent non-emergency behavioral health care: 48 hours</i> e. <i>ASAM Level 3.3, 3.5, and 3.7: 10 business days</i> f. <i>Residential withdrawal management: 24 hours when medically necessary</i> g. <i>Psychiatric Residential Treatment Facility (PRTF): 20 calendar days</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows: <ul style="list-style-type: none"> i. Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; ii. Primary dental care: within 30 days iii. Follow-up dental services: within 30 days after assessment <p><i>PIHP:</i></p> <ul style="list-style-type: none"> a. Urgent non-emergency behavioral health care: 48 hours 	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 159.201 Provider Accessibility and Availability Standards 	
Hospital and Emergency Services Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1</p>	<p>3. <i>MCO:</i></p> <ul style="list-style-type: none"> a. Emergency care: 24 hours, 7 days/week within one hour of request b. Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request c. After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes <p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; <p><i>PIHP:</i></p> <ul style="list-style-type: none"> a. Emergent care: 24 hours, 7 days/week within one hour of request b. Emergent, crisis or emergency services must be available at all times. c. Urgent care: 24 hours, 7 days/week within 48 hours of request 	<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/></p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Policy 159.201 Provider Accessibility and Availability Standards 	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. <i>MCO:</i> a. <i>OB/GYN care for pregnant women:</i> i. <i>1st trimester: 14 days</i> ii. <i>2nd trimester: 7 days</i> iii. <i>3rd trimester: 3 days</i> iv. <i>High risk pregnancy, any trimester: 3 days</i> b. <i>Family planning appointments: 1 week</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: None PAHP Contract: None PIHP Contract: None	5. <i>MCO: 45 minutes for scheduled appointments</i> <i>PAHP:</i> <i>PIHP:</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 220 ACLA 2024 SA2, tab 2 Ratios, lines 16 through 34 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: None PAHP Contract: None PIHP Contract: None	3. <i>Acute Inpatient Hospitals</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	4. <i>Laboratory</i> 5. <i>Radiology</i> 6. <i>Pharmacy</i> 7. <i>Hemodialysis Centers</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 220 ACLA 2024 SA2, Tab 1 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
	<ul style="list-style-type: none"> lab (line 19), radiology (line 71), pharmacy (line 25), hemodialysis centers (not mapped on 220, evidence not available) 	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. <i>OB/GYN: 1:10,000</i> 9. <i>Allergy/Immunology: 1:100,000</i> 10. <i>Cardiology: 1:20,000</i> 11. <i>Dermatology: 1:40,000</i> 12. <i>Endocrinology and Metabolism: 1:25,000</i> 13. <i>Gastroenterology: 1:30,000</i> 14. <i>Hematology/Oncology: 1:80,000</i> 15. <i>Nephrology: 1:50,000</i> 16. <i>Neurology: 1:35,000</i> 17. <i>Ophthalmology: 1:20,000</i> 18. <i>Orthopedics: 1:15,000</i> 19. <i>Otorhinolaryngology/Otolaryngology: 1:30,000</i> 20. <i>Urology: 1:30,000</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> 220 ACLA 2024 SA2, tab 2 Ratios, lines 38-63 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None	21. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> Medicaid Membership by PCP – December 2024 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
PIHP Contract: None 42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	22. Adult Physician Extenders: 1:1,000 Evidence as submitted by the MCE: <ul style="list-style-type: none"> Medicaid Membership by PCP – December 2024 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	23. Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500 Evidence as submitted by the MCE: <ul style="list-style-type: none"> Medicaid Membership by PCP – December 2024 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	24. Pediatric Physician Extenders: 1: 1,000 Evidence as submitted by the MCE: <ul style="list-style-type: none"> Medicaid Membership by PCP – December 2024 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: 2.6.2.6.1 PIHP Contract: None	<ol style="list-style-type: none"> 1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 3. <i>Primary Dental Services:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles one-way</i> b. <i>Urban Parishes: 10 miles</i> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 220 ACLA 2024 SA1, Report Attestation Tab, 220 ACLA 2024 SA1 PH Distance – Maps and Detail <ul style="list-style-type: none"> ○ 1a – page 13 ○ 1b – page 11 ○ 2a – page 18 ○ 2b – page 16 • Dental – N/A 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F	<ol style="list-style-type: none"> 4. <i>Acute Inpatient Hospitals</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 220 ACLA 2024 SA1, Report Attestation Tab, 220 ACLA 2024 SA1 PH Distance – Maps and Detail 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
PAHP Contract: None PIHP Contract: None	<ul style="list-style-type: none"> ○ 4a – page 33 ○ 4b – page 31 	
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	<ol style="list-style-type: none"> 5. <i>Laboratory:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 20 miles</i> 6. <i>Radiology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 20 miles</i> 7. <i>Pharmacy:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 8. <i>Hemodialysis Centers:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> ● 220 ACLA 2024 SA1, Report Attestation Tab, 220 ACLA 2024 SA1 PH Distance – Maps and Detail <ul style="list-style-type: none"> ○ 5a – page 38 ○ 5b – page 36 ○ 6a – page 43 ○ 6b – page 41 ○ 7a – page 48 ○ 7b – page 46 ○ 8a – page 53 ○ 8b – page 51 	
Specialty Care		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: 2.6.2.6.2 PIHP Contract: None	9. <i>OB/GYN:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 10. <i>Allergy/Immunology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 11. <i>Cardiology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 12. <i>Dermatology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 13. <i>Endocrinology and Metabolism:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 14. <i>Gastroenterology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 15. <i>Hematology/Oncology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 16. <i>Nephrology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 17. <i>Neurology:</i> <i>a. Rural Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist	
Reference	Required Components
	<p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>18. <i>Ophthalmology:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>19. <i>Orthopedics:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>20. <i>Otorhinolaryngology/Otolaryngology:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>21. <i>Urology:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>22. <i>Psychiatrists:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 30 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 15 miles</i></p> <p>23. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>24. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:</i></p> <p style="margin-left: 40px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 40px;"><i>b. Urban Parishes: 60 miles</i></p> <p>25. <i>Specialty Dental Services</i></p> <p style="margin-left: 40px;"><i>a. Travel distance shall not exceed 60 miles one-way from the enrollee’s place of residence for at least 75% of enrollees.</i></p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 220 ACLA 2024 SA1, Report Attestation Tab, 220 ACLA 2024 SA1 PH Distance – Maps and Detail <ul style="list-style-type: none"> ○ 9a – page 58 ○ 9b – page 56 ○ 10a – page 63 ○ 10b – page 61 ○ 11a – page 68 ○ 11b – page 66 ○ 12a – page 73 ○ 12b – page 71 ○ 13a – page 78 ○ 13b – page 76 ○ 14a – page 83 ○ 14b – page 81 ○ 15a – page 88 ○ 15b – page 86 ○ 16a- page 93 ○ 16b – page 91 ○ 17a – page 98 ○ 17b – page 96 ○ 18a – page 103 ○ 18b – page 101 ○ 19a – page 108 ○ 19b – page 106 ○ 20a – page 113 ○ 20b – page 111 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<ul style="list-style-type: none"> ○ 21a – page 118 ○ 21b – page 116 ● ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 22a – page 10 ○ 22b – page 9 ○ 23a – page 14 ○ 23b – page 13 ○ 24a – page 18 ○ 24a – page 17 ○ 25a – N/A 	
Licensed Mental Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	26. <i>Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> ● ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ a – page 22 ○ b – page 21 	
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	27. <i>PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization</i> <i>a. Rural and Urban Parishes: 200 miles</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> ● ACLA BH Geo Maps – Distance 2024_Q3, page 28 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	28. <i>ASAM Level 1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 29. <i>ASAM Level 2.1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 30. <i>ASAM Level 2WM:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 28a – page 33 ○ 28b – page 32 ○ 29a – page 37 ○ 29b – page 36 ○ 30a – page 41 ○ 30b – page 40 	
Substance Use Residential Treatment Facilities (adult)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	31. <i>ASAM Levels 3.1</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 32. <i>ASAM Levels 3.3</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 33. <i>ASAM Levels 3.5</i> <i>a. Rural Parishes: 30 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<p><i>b. Urban Parishes: 30 miles</i></p> <p>34. <i>ASAM Levels 3.2-Withdrawal Management</i></p> <p><i>a. Rural Parishes: 60 miles</i></p> <p><i>b. Urban Parishes: 60 miles</i></p> <p>35. <i>ASAM Level 3.7</i></p> <p><i>a. Rural Parishes: 60 miles</i></p> <p><i>b. Urban Parishes: 60 miles</i></p> <p>36. <i>ASAM Level 3.7-Withdrawal Management</i></p> <p><i>a. Rural Parishes: 60 miles</i></p> <p><i>b. Urban Parishes: 60 miles</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 31a – page 45 ○ 31b – page 44 ○ 32a – page 53 ○ 32b – page 52 ○ 33a – page 57 ○ 33b – page 56 ○ 34a – page 49 ○ 34b – page 48 ○ 35a – page 61 ○ 35b – page 60 ○ 36a – page 65 ○ 36b – page 64 	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	<p>37. <i>ASAM Level 3.1</i></p> <p><i>a. Rural Parishes: 60 miles</i></p> <p><i>b. Urban Parishes: 60 miles</i></p>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	38. <i>ASAM Level 3.2 Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 39. <i>ASAM Level 3.5</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 37a – page 67 ○ 37b – page 67 ○ 38a – page 70 ○ 38b – page 70 ○ 39a – page 73 ○ 39b – page 73 	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	40. <i>Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 90 miles</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 40a – page 82 ○ 40b – page 81 	
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	41. <i>Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • ACLA BH Geo Maps – Distance 2024_Q3 <ul style="list-style-type: none"> ○ 41a – page 78 ○ 41b – page 77 	
Behavioral Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	42. <i>For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	43. <i>For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Care Coordination and Services		
<i>Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).</i>		
<p>1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member.</p> <p style="margin-left: 20px;">a. The member is provided information on how to contact their designated person or entity.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(1) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Member materials, such as the member handbook or member notice Primary care provider (PCP) assignment algorithm Screenshot of member identification (ID) card Screenshot of fields designating the assigned PCP and assigned case manager HSAG will also use the results of the case file reviews <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Member HB English Version_Audit, pages 16, 35 ACLA Revision to Member ID Card_v05 156.701 Coordination with Other Healthcare and Non-Healthcare Services, pages 6, 7 2024 Program Description, page 43, sentence # 3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Assigned PCP and Case Manager (Jiva 6.3 screenshot) MCO PCP Auto Assignment Methodology <p>Additional Documentation:</p> <ul style="list-style-type: none"> 2024 PHM Program Description RE ACLA PCP Assignment ACLA-1734 Submission 	
<p>MCE Description of Process: Care Managers, Care Connectors or Community Health Navigators who work directly with Enrollees ensure that they have an assigned primary care provider; this information can be confirmed in Jiva case management system. Each enrollee is provided contact information for their case manager and informed regarding member services contact information on the back of their ID card.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendations: HSAG recommends that the MCE consider revisions to its internal processes to ensure timely review and approval of policies and procedures by leadership and the medical director.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE coordinates the services the MCE furnishes to the member:</p> <ol style="list-style-type: none"> a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. <p>MCO:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Transition of care program Workflow for coordinating with other MCOs/ PIHPs/PAHPs Workflow for coordinating with FFS Workflow for coordinating with community and social support resources HSAG will also use the results of the case file reviews 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>a. <i>Coordinate care between network PCPs and specialists, including specialized behavioral health providers;</i></p> <p>b. <i>Coordinate care for out-of-network services, including specialty care services;</i></p> <p>c. <i>Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;</i></p> <p>d. <i>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.</i></p> <p>PAHP:</p> <p>a. Coordination with the enrollee’s MCO:</p> <p style="margin-left: 20px;">i. <i>for oral health issues exceeding the coverage of the Contract;</i></p> <p style="margin-left: 20px;">ii. <i>for transportation to and from covered dental services; and</i></p> <p style="margin-left: 20px;">iii. <i>regarding value-added dental benefits offered by the enrollee’s MCO.</i></p> <p>PIHP:</p> <p>a. <i>Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.</i></p> <p>b. <i>Coordinate care for out-of-network services.</i></p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC workflow • 156.PH-CM 207 Transitions of Care Clinical Pathway Final 12.1.2022 • 156.900 - Continuity for Behavioral Healthcare & Care Coordination with Primary Care and Behavioral Health Providers 2.13.2024, page 5 & 6, # 1 – 10 • 2024 Program Description, page 6, last paragraph line 7 • P&P Housing Navigation Services ACLA • Coordination with DCFS (email) • Coordination with LDH (email) <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2024 PHM Program Description • Coordinated System of Care (CSOC) Workflow 8.16.24. • Housing Navigation Services 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>c. <i>Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.</i></p> <p>d. <i>Coordinate timely with Integrated Medicaid Managed Care Programs and the member’s family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7</p>		
<p>MCE Description of Process: ACLA ensures coordination of care between physical health and behavioral health network PCPs, specialists, out-of network services and all other health care providers. MCO ensures coordination with state agencies, court system and will attend court proceedings as requested by LDH. There are no standardized workflows to provide for the coordination process as these occur through multiple channels and contacts, so we have submitted evidence of such collaboration with other state agencies.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element because the submitted document was not specific to Louisiana Medicaid nor applicable for the review period.</p>		
<p>Required Actions: The MCE must revise the policy, Housing Navigation Services, to include Louisiana Medicaid and revision/review, and approval as contractually required.</p>		
<p>3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide procedures and criteria for making referrals and coordinating care with</i></p>	<p>HSAG Required Evidence:</p> <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.700 Member Transition of Care (Continuity of Care) page 8- Transition to/from another MCO or Medicaid FFS 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><i>behavioral health and primary care providers and agencies that will promote continuity of care. These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8</p>	<ul style="list-style-type: none"> 156.900 - Continuity for Behavioral Healthcare & Care Coordination with Primary Care and Behavioral Health Providers 2.13.2024, entire policy 	
<p>MCE Description of Process: ALCA’s procedure that includes identification criteria, process, and triggers for referral and admission into Care Management for coordination of care, including a process to offer voluntary participation in Care Management to Enrollees. Enrollees are referred through any of the following mechanisms:</p> <ul style="list-style-type: none"> Health Needs Assessment Identification of individuals with special health care needs External referrals including but not limited to self-referral by Member and/or referral from the Primary Care Practitioner (PCP), Specialist or another provider Internal department referrals including but not limited to Utilization Management (UM), Appeals Department, Member Services and Quality Management (QM) Internal process referrals arising from plan processes such as New Member Assessment, Care Gap outreach, 24/7 call follow-up and/or EPSDT outreach External program referrals through contracted vendors Monthly predictive modeling reports using software algorithms provided by claims and pharmacy data Regulatory agency referrals Referrals related to members identified with need for non-covered, excluded services Community Care Management Team 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> Referrals from State Agencies Primary Care Physicians, Providers (including primary care, behavioral health, and specialist providers); Psychiatrist. Behavioral health specialist, Providers qualified to perform comprehensive diagnostic evaluation (CDE) Occupational therapists, physical therapists and speech and other specialist 		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information Sharing		
<p>4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities</p> <p>MCO: a. <i>Upon written request</i></p> <p style="text-align: right;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow for sharing assessment results with the State Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs Care management program description Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 156.701 Coordination with other healthcare and non-healthcare services 06.05.24, page 7, bullet # 6 2024 PHM Program Description, page 52-53 Assessment – Merakey Assessment – DOC Assessment – LDH 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Assessment – Merakey Assessment – DOC Assessment - LDH 	
MCE Description of Process: Upon receipt of written request and approval by Compliance Director, ACLA will share (via secure file) with LDH and other health care entities the results, identification and assessment of Enrollees with special health care needs to prevent duplication of assessment activities. There is no standardized workflow to provide nor examples, as there have been no requests received for this documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.</p> <p style="text-align: right;">42 CFR §438.208(b)(5) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.7 PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1 PIHP Contract: 16.15</p>	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Care management program description Provider materials, such as the provider manual and provider contract Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices Evidence as Submitted by the MCE: <ul style="list-style-type: none"> 159.302 Provider Contracts page 9 ACLA Provider Handbook for December 2024-FINAL page 32 053024-provider-alert-medical-record-requests Results of Medical Record Reviews – 358 Reports 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Results of Medical Record Reviews – 411 Reports All MCO PQM Strategy_Final July 2024 156.900 - Continuity for Behavioral Healthcare & Care Coordination with Primary Care and Behavioral Health Providers 2.13.2024, page 5 	
<p>MCE Description of Process: ACLA maintains policy and procedure stating that all providers furnishing services to Enrollees maintain and share the Enrollees’ health record in accordance with professional standards. Confirmation of this compliance is reviewed during regular monitoring and any FWA investigations, as applicable.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE ensures that in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.</p> <p style="text-align: right;">42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E</p> <p>MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024- FINAL page 19, 20 159.302 Provider Contracts page 9 UM.700 Member Transition of Care (Continuity of Care) page 12 Policy 669-200 Authorization to Use or Disclose PHI: Entire Policy Policy 669-206 Disclosure of PHI As Required by Law: Entire Policy 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Policy 669-208 Disclosures of PHI to Personal Representatives: Entire Policy Policy 669-209 Disclosure of PHI to BAs and Other Contractors: Entire Policy Policy 669-213 Safeguards to Avoid Disclosures of PHI PII Sensitive Data: Entire Policy Policy 669-216 Providing Medical Info to Others Involved in Care: Entire Policy Policy 669-217 Minimum Necessary Standard: Entire Policy 	
<p>MCE Description of Process: As permitted by applicable HIPAA privacy regulations and other state and Federal laws and regulations pertaining to confidentiality and privacy, MCO shares assessment findings related to a member’s health care and related needs with other health care entities serving the Member. Per policy and procedure associates may not Use, Request, or Disclose to others, any PHI that is more than the Minimum Necessary to accomplish the purpose of the Use, Request, or Disclosure. MCO maintains adequate administrative, technical, and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards are also utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Initial Health Risk Screening		
<p>7. The MCE makes a best effort to conduct an initial screening of each member’s needs within MCO:</p> <p>a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Initial screening template Initial screening tracking and monitoring mechanisms and subsequent results/reports 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><i>The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.</i></p> <p>PAHP:</p> <p>a. <i>The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee’s enrollment to conduct an initial screening of the enrollee’s needs and to offer to schedule the enrollee’s initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA</p>	<ul style="list-style-type: none"> HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Corporate Wellness Coordination: Rapid Response and Outreach Team (RROT) Health Needs Assessment ACLA HNA Presentation FINAL 156.PH - CM.005 - Conducting the Health Risk Assessment, pages 1 and 2 of addendum Initial Assessment ACLA HRA Workflow 9.13.24 	
<p>MCE Description of Process: ACLA utilizes a multi prong approach with a goal to achieve the highest Health Needs Assessment (HNA) completion rates possible by focusing on the following areas:</p> <p>a) The HNA is mailed to Enrollees in the welcome packet sent to all new Enrollees within 10 business days from the receipt of the 834-enrollment file.</p> <p>b) The Enrollee will have the option to mail in the HNA with a company addressed stamped envelope or fax the HNA back to the Rapid Response Outreach Team.</p> <p>c) The Enrollee’s Outreach associate will complete the HNA during the new Member welcome call.</p> <p>d) Community Wellness Centers: The Enrollee is able to complete the HNA in person at the health plan’s Wellness Center.</p> <p>The health plan will attempt outbound phone calls on at least three different occasions, at different times of the day and on different days of the week, along with text message reminders, to encourage HNA completion within the initial 90-day period.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<p>a) If our initial attempt to contact Enrollees for HNA completion is unsuccessful, their names will be added to the HNA gap report.</p> <p>b) The HNA gap report will be viewable via our population Health Platform during member’s interactions with Care Managers, Enrollee Services staff, ACLA Peer Support Specialists, the Rapid Response Outreach Team (RROT), and other staff who will remind Enrollees about the importance of completing their HNA.</p> <p>3. All HNA results will be documented in Jiva, the health plan’s electronic care management system, and along with prior authorizations, will be used to inform the risk stratification tier for each Member, and determine the appropriate care coordination assignment using data analytics to generate a Predictive Intervention of Care Management Services (PICS) score.</p> <p>4. There will be specific triggers in the HNA that guides the next intervention for the Member such as but not limited to the following:</p> <p>a) Member with social determinants of health need(s): a referral will be made to the Rapid Response Outreach Team to connect the Member to the appropriate community resources.</p> <p>b) Pregnancy: Member will be referred to the Bright Start® Maternity Program</p> <p>c) Member is part of a high-risk population: a referral will be made to the Rapid Response Outreach Team for further evaluation of care coordination needs.</p> <p>5. The health plan will follow up with Members that have partially completed HNAs. A HNA will be considered to be complete when all the responses to the questions are answered even if the response is “I choose not to answer this question.”</p>	
	<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that ACLA had policies, procedures, and mechanisms to conduct the initial health needs assessment (HNA); however, results from the virtual case management performance evaluation (CMPE) file review demonstrated noncompliance with timely completion of the initial HNA.</p>	
	<p>Required Actions: The MCE must conduct an initial screening of each member’s needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the HNA on at least three different occasions, at different times of the day and on different days of the week. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of the initial HNA. This process must include HNA time frame monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.</p>	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Comprehensive Assessment		
<p>8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.</p> <p>a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.</i></p> <p style="text-align: right;">42 CFR §438.208(c)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS Comprehensive assessment template HSAG will also use the results of the case file reviews <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 156.PH-CM.005 Conducting the Health Risk Assessment, pages 7-8, addendum page 3 Initial Assessment 2024 PHM Program Description, page 45 156.PH-CM.001 Complex Care Management Standards of Practice, pages 19-21 <p>Additional Documentation:</p> <ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 10.01.2024 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 4 21 2023 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: All Enrollees with special health care needs are identified based on established criteria, and each Enrollee is contacted to offer care management services. If an Enrollee agrees to case management services, a comprehensive assessment is completed by a care manager in an effort to identify any ongoing special conditions of the Enrollee that require treatment or regular monitoring.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the CMPE file review demonstrated overall compliance with timely completion of the comprehensive assessments and reassessments.</p> <p>Recommendations: HSAG recommends that the MCE consider revisions to its internal processes to ensure timely review and approval of policies and procedures by leadership and the medical director.</p>		
<p>Required Actions: No action required.</p>		
Treatment/Service Plan		
<p>9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.</p> <p style="text-align: right;">42 CFR §438.208(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Care management program description • Person centered treatment plan template • HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 156.PH-CM.001 Complex Care Management Standards of Practice, page 21, addendum - page 6, 4th and 5th bullet • Plan of Care template • 2024 PHM Program Description, pages 44-45 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 10.01.2024 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 4 21 202 	
<p>MCE Description of Process: For all members who agree to case management services, a comprehensive individualized person-centered plan of care is developed by enrollee and case manager with input from the interdisciplinary care team and maintained in our Jiva case management system. The plan of care includes collaboration, coordination and integration of services by different departments, contractors and/or LDH. The plan of care is updated at minimal based on frequency required by tiered case management.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the CMPE file review demonstrated overall compliance with timely completion of a plan of care (POC).</p> <p>Recommendations: HSAG recommends that the MCE consider revisions to its internal processes to ensure timely review and approval of policies and procedures by leadership and the medical director.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The treatment or service plan is:</p> <ul style="list-style-type: none"> a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the MCE in a timely manner, if this approval is required by the MCE. d. In accordance with any applicable State quality assurance and utilization review standards. <ul style="list-style-type: none"> 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Case management program description Staff qualifications for developing care plans and service plans (e.g., job description) Service plan approval process Mechanisms to actively involve the member and the member’s formal and informal supports in the development of the treatment plan Mechanisms to actively involve the member’s PCP (and any other providers involved in the member’s care) in the development of the treatment plan HSAG will also use the results of the case file reviews 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice, pages 21-22, addendum – page 7, bullet # 2 2024 PHM Program Description, pages 44-45 <p>Additional Documentation:</p> <ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 10.01.2024 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 4 21 202 	
<p>MCE Description of Process: A comprehensive individualized person-centered plan of care is developed by enrollee and case manager with input from the interdisciplinary care team. Care managers work with behavioral health providers to ensure inclusion and implementation of enrollee’s treatment plans in plan of care. ACLA does not provide for LTSS treatment, so evidence is applicable to other services and populations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance in development of POCs that are person-centered and include goals, risks, behavioral health, and supports.</p> <p>Recommendations: HSAG recommends that the MCE consider revisions to its internal processes to ensure timely review and approval of policies and procedures by leadership and the medical director.</p>		
<p>Required Actions: No action required.</p>		
11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member’s circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3).	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Care plan and service plan review and revision tracking mechanism 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary</p>	<ul style="list-style-type: none"> HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice, page 22, addendum – page 7, bullet RR_3138_dailyCaseManagement_03DEC2024 <p>Additional Documentation:</p> <ul style="list-style-type: none"> 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 10.01.2024 156.PH-CM.001 Complex Care Management Standards of Practice FINAL 4 21 202 	
<p>MCE Description of Process: The comprehensive individualized person-centered plan of care is developed by enrollee and case manager with input from the interdisciplinary care team. The plan of care is reviewed and revised with each assessment, change in member’s health status, newly identified diagnosis, etc. At minimal the plan of care is updated based on tiered case management model.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the CMPE file review demonstrated overall compliance with conducting timely POC updates.</p>		
<p>Recommendations: HSAG recommends that the MCE consider revisions to its internal processes to ensure timely review and approval of policies and procedures by leadership and the medical director.</p>		
<p>Required Actions: No action required.</p>		
Direct Access to Specialists		
<p>12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.</p> <p style="text-align: right;">42 CFR §438.208(c)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1</p>	<ul style="list-style-type: none"> Member materials, such as the member handbook or benefits grid Provider materials, such as the provider manual or provider contracts <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA Provider Handbook for December 2024-FINAL, page 132 2024 Member HB English Version_Audit, pg. 41 UM.700 Member Transition of Care (Continuity of Care) page 2, Policy section; UM.700 Member Transition of Care (Continuity of Care) page 3, Newly Enrolled Members with Special Healthcare Conditions 156.900 - Continuity for Behavioral Healthcare & Care Coordination with Primary Care and Behavioral Health Providers 2.13.2024, P & P purpose 	<input type="checkbox"/> NA
<p>MCE Description of Process: Care managers work with Enrollees with special health care needs to ensure referral to appropriate specialist based on Enrollees condition and/or need. If network specialist is not available case manager work with provider network manager to initiate single case agreement.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Results for Standard VI—Coordination and Continuity of Care						
Total	Met	=	10	X	1	= 10
	Not Met	=	2	X	0	= 0
	Not Applicable	=	0			
Total Applicable		=	12	Total Score	=	10

Total Score ÷ Total Applicable	=	83%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Coverage		
<p>1. The MCE:</p> <p style="margin-left: 20px;">a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer.</p> <p style="margin-left: 20px;">b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B.</p> <p style="margin-left: 20px;">c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.</p> <p style="margin-left: 40px;">42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3 PAHP Contract: 2.4.1.4 PIHP Contract: 4.1.2; 4.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook and benefits grid Utilization Management (UM) program description Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> (a)UM.500 Covered Benefits and Services page 1 (b) UM.500 Covered Benefits and Services page 2; UM.003 Standard and Expedited Prior Authorization (c)UM.500 Covered Benefits and Services page 2 2024 ACLA Utilization Management Program Description Page 3 (Purpose and Scope Sections) Coverage guidelines/criteria- UM.500 Covered Benefits and Services page 2 (Policy Section) 2024 Member HB English Version_Audit: Pg. 11 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA covers benefits consistent with state Medicaid requirements. ACLA will cover and ensure members have timely access to all medically necessary services described in state specific contract and/or regulations and the services listed within this document, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right;">42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.003 Standard and Expedited Prior Authorization page 7 • 2024 ACLA Utilization Management Program Description Page 16 • Coverage guidelines/criteria- UM.003 Standard and Expedited Prior Authorization page 7 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: ACLA does employ utilization management techniques, including referrals, notifications and Medical Necessity review (using the state specific definition of Medical Necessity), to evaluate the appropriateness of services. ACLA will not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition of the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Utilization management plan • Member materials, such as the member handbook • Coverage guidelines/criteria 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>MCO, PAHP, and PIHP:</p> <p>a. The services furnished can reasonably achieve their purpose.</p> <p>MCO and PIHP:</p> <p>a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member’s ongoing need for such services and supports.</p> <p>b. Family planning services are provided in a manner that protects and enables the member’s freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.</p> <p style="text-align: right;">42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> (a-b) UM.003 Standard and Expedited Prior Authorization page 7 Coverage guidelines/criteria- UM.003 Standard and Expedited Prior Authorization page 2 (Policy Section) 2024 ACLA Utilization Management Program Description page 15 2024 Member HB English Version_Audit: Standard VII 3a. pg. 22 2024 Member HB English Version_Audit: Standard VII 3b. Pg. 11 and 29 	
<p>MCE Description of Process: In accordance with 42 CFR 438.210, the ACLA may exclude or place appropriate limits on service coverage, as specified in state Medicaid contracts, with the exception of emergency and post-stabilization services. ACLA will permit members to self-refer for family planning services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a qualified family planning provider.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>4. The MCE specifies what constitutes “medically necessary services” in a manner that:</p> <p style="margin-left: 20px;">a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and</p> <p style="margin-left: 20px;">b. Addresses the extent to which the MCE is responsible for covering services that address:</p> <p style="margin-left: 40px;">i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability.</p> <p style="margin-left: 40px;">ii. The ability for a member to achieve age-appropriate growth and development.</p> <p style="margin-left: 40px;">iii. The ability for a member to attain, maintain, or regain functional capacity.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(a)(5)</p> <p>MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> (a) UM.500 Covered Benefits and Services page 6 (b) UM.500 Covered Benefits and Services page 2 2024 ACLA Utilization Management Program Description Page 12 2024 Member HB English Version_Audit: Standard VII 4.b. Pg. 40 ACLA Provider Handbook for December 2024-FINAL pg 133-135 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: By facilitating the delivery of Medically Necessary state specific Core Benefits and Services as identified in the contract, combined with supportive health education, connections to community services and evaluation of outcomes, and access to ACLA-specific value-added services, In Lieu of Services, and programs, ACFC provides the infrastructure necessary to help ensure:</p> <ul style="list-style-type: none"> The prevention, diagnosis, and treatment of health impairments; The ability to achieve age-appropriate growth and development; and The ability to attain, maintain, or regain, functional capacity. 		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Authorization of Services		
<p>5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services.</p> <p style="text-align: right;">42 CFR §438.210(b)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Coverage guidelines/criteria List of delegated entities performing utilization management Delegated written contract (for entities responsible for delegated UM functions) Delegation oversight of policies and procedures (e.g., audit results) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Standard VII Element 5 entire document Standard VII Element 5 List of Delegated Entities BHM MSA 03.docx page 6 Evolent-Enterprise Standalone Agreement 20140228 page 19 20231028 PBM Standalone Agreement pages 21 and 60 20231028 PerformRx Amendment page 2 2024 Delegation Oversight Policy 277.010 pages 3 and 4 ACLA_Standard VII_BHM CLP-OP-08 IR Process-Internal 2024.03.26 ACLA_Standard VII_BHM.2024 IRR Results 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> ACLA_Standard VII_BHM.2024 Program Evaluation_Shareable ACLA_Standard VII_BHM. CLP-OP-02 Access to Review Staff_2024.02.15 ACLA_Standard VII_BHM.CLP-OP-06 Clinical Review Criteria_2024.02.15 ACLA_Standard VII_BHMCLP-op-01 2024 BHM UMQM Program_2024.03.26 ACLA_Standard VII_Evolent. CO.283.04 Medical Necessity Determination Process ACLA_Standard VII_Evolent. 2024 NIA Advanced Imaging Guidelines ACLA_Standard VII_Evolent. Clinical Review ACLA_Standard VII_Evolent. MP.800 - Appropriate Application of Clinical Criteria ACLA_Standard VII_Evolent..MP.802 - Evolent Clinical Guideline and Algorithm Review Process ACLA_Standard VII_Evolent.2024 ESS QIUM Program Evaluation_Final_Approved ACLA_Standard VII_Evolent.2024 NIA Expanded Cardiac Guidelines ACLA_Standard VII_Evolent.CO.283.04 Medical Necessity Determination Process ACLA_Standard VII_Evolent.CO.323 Clinical Guideline Hierarchy Evolent Specialty Services ACLA_Standard VII_Evolent.CO.MCD.244.12 Medicaid Service Authorization Determination 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • ACLA_Standard VII_Evolent.CO.MCD.244.12.AmerihealthLA.A A Medicaid Service Authorization Determination • ACLA_Standard VII_Evolent.CO.MCD.248.01 Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • ACLA_Standard VII_PerformRx.2024 PRx UM Program Description • ACLA_Standard VII_PerformRxCORE 1-01 • ACLA_Standard VII_PerformRxDRUM 2-01 • ACLA_Standard VII_PerformRxDRUM 2-02 • ACLA_Standard VII_PerformRxDRUM 2-05 • ACLA_Standard VII_PerformRxDRUM 2-06 • ACLA_Standard VII_PerformRxDRUM 2-10 • ACLA_Standard VII_PerformRxDTM 2-01 • ACLA_Standard VII_PrimeLA SPBM-Operations Manual v6.0 draft • ACLA_Standard VII_PrimeMedicaid Service Authorization Determination • ACLA_Standard VII_PrimeMedical_Necessity_Criteria_Development_and_Review • ACLA_Standard VII_PrimeMedical_Necessity_Criteria_Development_and_Review • UM.002 Concurrent Review pages 1,3 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 2024 ACLA Utilization Management Program Description Page 4 (Program Structure) , Page 15 (Prior Authorization)- page 16 (Concurrent Review) Coverage guidelines/criteria- UM.002 Concurrent Review page 2, procedure 1 	
<p>MCE Description of Process: ACLA’s Utilization Management program follows the written guidelines for the processing of requests for initial and continuing authorization of services. ACLA reviews subcontractor policies and procedures on an annual basis to validate that they reflect all state, federal and NCQA requirements. As part of the annual review, a random sample of files is selected. The files are reviewed to ensure that all requirements are met. UM reviews policies and procedures on an annual basis or ad-hoc, updating in accordance with the Medicaid contract. UM Policies are reviewed and voted on in a committee.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Coverage guidelines/criteria Results of inter-rater reliability (IRR) activities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.708 Inter-Rater Reliability page 1 Coverage guidelines/criteria- UM.708 Inter-Rater Reliability page 2, procedure 1 UM.008 Utilization Management Clinical Criteria Policy pages 7 and 10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 2024 ACLA Utilization Management Program Description page 14 ACLA Semi-Annual Utilization Management Associates IRR Report 2024 ACLA Semi-Annual Utilization Management Associates IRR Report 2nd Test 2024 <p>Additional Documentation:</p> <ul style="list-style-type: none"> UM.708 Inter-Rater Reliability Policy 	
<p>MCE Description of Process: Utilization Management staff are tested twice a year to assess their understanding of InterQual. Staff must pass with a score of 90% or greater. Any staff scoring less than 90% are required to attend a refresher course.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE consults with the requesting provider for medical services when appropriate.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Provider materials, such as the provider manual, provider communications Three case examples of peer-to-peer consults <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.105 Peer to Peer Discussion pages 1, 5 2024 ACLA Utilization Management Program Description page 13 Determination Fax Copy_Redacted 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Stad VII Elm 7 Peer to Peer example #1 Stad VII Elm 7 Peer to Peer example #2 Stad VII Elm 7 Peer to Peer example #3 ACLA Provider Handbook for December 2024-FINAL page 65 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Peer to peer approval letter example #3 	
<p>MCE Description of Process: Providers are provided an opportunity to discuss a medical denial and provide further evidence for medical appropriateness with the determining physician reviewer.</p>		
<p>HSAG Findings: HSAG has scored this element as not applicable since State requirements differ from federal requirements. In the virtual review, ACLA staff members described that when a prior authorization request is denied by a reviewer (such as medical director), the provider is issued an adverse benefit determination (ABD) notice via fax and letter which informs the provider of the right to request a peer-to-peer (within a specified time frame). An ABD notice is also sent to the member at this point in time (prior to the peer-to-peer). If requested, a peer-to-peer consultation is scheduled, and if the denial decision is overturned, that is noted in the member record and the service is approved. At this point, all the notifications are regenerated indicating approval. ACLA’s documentation and its description of this process during the virtual review indicated that it has an informal reconsideration process as per its contract with LDH. However, CMS has articulated that MCEs’ practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member an ABD notice is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS’ definition of an appeal. HSAG has communicated this information to LDH.</p>		
<p>Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		
<p>8. The MCE authorizes LTSS based on a member’s current needs assessment and consistent with the person-centered service plan.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(iii)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Authorization workflow for LTSS UM program description 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	<ul style="list-style-type: none"> Coverage guidelines/criteria Three examples of authorized LTSS and copies of the corresponding person-centered service plans <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> NA 	
MCE Description of Process: Not applicable		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member’s medical, behavioral health. MCO: a. <i>The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.</i> PAHP: a. <i>Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has</i>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Job descriptions for UM decision makers HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.003 Standard and Expedited Prior Authorization page 8 2024 ACLA Utilization Management Program Description page 10 (UM Staff), pages 11-12 (Table A), page 12 (Medical Necessity Decision Making) ACLA_Standard VII_PerformRxDRUM 2-02 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>appropriate clinical experience in treating the enrollee’s condition.</i></p> <p style="text-align: center;">42 CFR §438.210(b)(3) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3</p>		
<p>MCE Description of Process: Any decision to deny, alter, or approve coverage for an admission, service, procedure, or extension of stay in an amount, duration, or scope that is less than requested is made by the AmeriHealth Medical Director, Behavioral Health Medical Director, or physician designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notice of Adverse Benefit Determination		
<p>10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.</i></p> <p>PIHP:</p> <p>a. <i>The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.017 Adverse Benefit Determination Policy page 7 • 2024 ACLA Utilization Management Program Description page 18 (Table B) • Determination Fax Copy_Redacted page 2 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p><i>The PIHP shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.</i></p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2</p>	<ul style="list-style-type: none"> • ACLA Provider Denial Template page 1 	
<p>MCE Description of Process: Utilization Management provides written notification to the rendering provider and member of adverse benefit determinations within the timeframes outlined in the contract and UM.010 Decision Response time policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The MCE defines an adverse benefit determination (ABD) as:</p> <ol style="list-style-type: none"> The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.017 Adverse Benefit Determination Policy page 6 • 2024 Member HB English Version_Audit: Standard VII. 11. Pg. 54 • ACLA Provider Handbook for December 2024-FINAL page 159 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>a service solely because the claim does not meet the definition of a “clean claim” is not an ABD.</p> <p>d. The failure to provide services in a timely manner, as defined by the State.</p> <p>e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.</p> <p>f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.</p> <p>g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.</p> <p style="text-align: right;">42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2)</p> <p>MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1</p>	<ul style="list-style-type: none"> • Provider-decision-response-time PDF 	
<p>MCE Description of Process: Utilization Management Adverse Benefit Determinations are requested services that are denied, in whole or part, that do not meet medical appropriateness, administratively denied if the plan does not notify the provider of a determination within the appropriate timeframe.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following:</p> <ol style="list-style-type: none"> a. The ABD the MCE has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member’s right to request an appeal of the MCE’s ABD, including information on exhausting the MCE’s one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.017 Adverse Benefit Determination Policy pages 8-9 • UM.010 Decision Response Time page 5 (Table 1) • 2024 ACLA Utilization Management Program Description page 18 • ACLA BH-IP MED NEC FULL DENIAL TEMPLATE <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Medical Director Determination, Page 2 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>g. The notice must be consistent with the requirements of 42 CFR §438.10.</p> <p style="text-align: center;">42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2</p>		
<p>MCE Description of Process: As described in UM.017 Notice of Adverse Benefit Determination, Utilization Management notifies the member in writing of any decision to deny services, in whole or part, denial rationale, criteria used in making the decision and free access to copies of the criteria; member’s appeal rights, process, including how to request an expedited appeal; and continuation of benefits during the appeal.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that the MCE ensure member notifications meet state-required reading levels and that the MCE’s documentation of reading levels for case files is accurately demonstrated. The MCE should add functionality to the system that houses and tracks prior authorization requests and resolutions so users may document that ABD notices include all requirements and indicate that the reading grade level has been verified.</p>		
<p>Required Actions: No action required.</p>		
Timeframe for Decisions		
<p>13. For standard authorization decisions, the MCE provides notice as expeditiously as the member’s condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.</p> <p style="text-align: center;">42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5</p>	<ul style="list-style-type: none"> HSAG will also use the data from the universe file HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.010 Decision Response Time page 5 (Table 1) 2024 ACLA Utilization Management Program Description page 18 BITS Screenshot PQ188_2024Q1 PQ188_2024Q2 PQ188_2024Q3 PQ188_2024Q4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Delegate Indicator Report 055 ACLA 2024 08 	
<p>MCE Description of Process: Utilization Management reviews standard prior authorization requests as expeditiously as possible but no more than 14 calendar days from when the request was received.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later 72 hours after receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.010 Decision Response Time page 5 (Table 1) • 2024 ACLA Utilization Management Program Description page 18 • BITS Screenshot • PQ188_2024Q1 • PQ188_2024Q2 • PQ188_2024Q3 • PQ188_2024Q4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Utilization Management determines an expedited/urgent prior authorization request as expeditiously as possible but not more the 72 hours from the receipt of the request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member, or the provider, requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member’s interest.</p> <p style="margin-left: 100px;">42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • Three case examples of authorizations with an extension, including the date of receipt of the authorization request and date of the decision to extend the time frame • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Utilization Management Program Description page 19 • UM.010 Decision Response Time page 2 • Extension notice example • BITS Screenshot • Std VII Elem 15&16 Extension example #1 • Std VII Elem 15&16 Extension example #2 • Std VII Elem 15&16 Extension example #3 • PQ188_2024Q1 • PQ188_2024Q2 • PQ188_2024Q3 • PQ188_2024Q4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Utilization Management (UM) may extend the time frame to an additional 14 days when it is in the best interest of the member. If requested by the state, UM will provide justification and how the extension is in the member’s best interest.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it:</p> <p style="margin-left: 20px;">a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and</p> <p style="margin-left: 20px;">b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.</p> <p style="margin-left: 40px;">42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Utilization Management Program Description page 18 preservice urgent table B-UM/Appeal Decision Notification Timeframes for Behavioral/Physical Health • UM.010 Decision Response Time page 2, procedure 2 • Extension notice example • Std VII Elem 15&16 Extension example #1 • Std VII Elem 15&16 Extension example #2 • Std VII Elem 15&16 Extension example #3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> PQ188_2024Q1 PQ188_2024Q2 PQ188_2024Q3 PQ188_2024Q4 	
<p>MCE Description of Process: If the time frame is extended, Utilization Management (UM) will notify the member of the extension and their right to file a grievance if they do not agree with the extension. UM will review, determine and provide the determination as expeditiously as possible.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA).</p> <p>a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.</p> <p style="text-align: right;">42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)</p> <p>MCO Contract: None PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Three examples of notice <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA_Standard VII_PrimeMedicaid Service Authorization Determination, pg 7 Std VII_Coverage and Auth of Services_Timeframe For Dec item 17 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Prime adheres to the requirements outlined in the single PBM contract.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214.</p> <p style="text-align: right;">42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Three case examples of advance notices, including the ABD notice and the effective date of decision • HSAG will also use the data from the universe file • HSAG will also use the results of the service authorization denial file review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.010 Decision Response Time page 2, procedure 3 • UM.017 Adverse Benefit Determination Policy page 9 • STD VII Elem 18 ABD Notice with Effective Date example #1 • STD VII Elem 18 ABD Notice with Effective Date example #2 • STD VII Elem 18 ABD Notice with Effective Date example #3 • Copy of denial letter_Redacted 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: There is no specific ABD notice template, but effective date language is included in denial letter page 5.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Tracking and reporting is done within the Medical Informatics System. If previously authorized services are denied, in whole or part, UM will notify the member at least 10 days prior to the action.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>19. The MCE may send a notice not later than the date of action if:</p> <ul style="list-style-type: none"> a. The MCE has factual information confirming the death of a member; b. The MCE receives a clear written statement signed by a member that: <ul style="list-style-type: none"> i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member’s physician; 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element (one example must apply to a deceased member, one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • UM.017 Adverse Benefit Determination Policy page 9 • BH-IP Med Nec Full Denial • Ineligible Letter_ page 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or</p> <p>h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i).</p> <p style="text-align: center;">42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3</p>		
<p>MCE Description of Process: As a result of our review of our Utilization Management authorizations for ACLA Medicaid members, these situations did not occur during the period being reviewed. This criterion is not addressed in the UM Program Description. However, UM would issue a denial in the situations/instances described above.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>20. The MCE may shorten the period of advance notice to five days before the date of action if:</p> <p>a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right;">42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2</p>	<ul style="list-style-type: none"> Three examples of an ABD notice sent to a member due to probable fraud HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.017 Adverse Benefit Determination Policy page 9 2024 ACLA Utilization Management Program Description page 16 	
<p>MCE Description of Process: UM did not have an instance where an advance notice needed to be shortened to 5 days. However, UM would do so if either of the two scenarios described were evidenced in the documentation received.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim.</p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow/guidelines for payment denial on a claim to trigger ABD notice UM program description ABD notice template for denial of payment Tracking and reporting mechanism(s) Three case examples of the denial of payment on a claim, including date of the denial and ABD notice HSAG will also use the data from the universe file 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> HSAG will also use the results of the Service Authorization Denial File Review 	
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 ACLA Utilization Management Program Description page 16 1. BRD - ACLA - 40133-Mega Regulations NABD Final - ACLA NABD Denied CODE LIST NABD Questions and Answers 	
<p>MCE Description of Process: If UM denies a request for services (prior authorization (standard or urgent), concurrent, or post-service), the provider and member will receive a written notice. AmeriHealth Caritas implemented business requirements for the company related to NABD requirements, which are attached. Not even claim denial results in an NABD issuance to the member.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire.</p> <p style="text-align: right;">42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description ABD notice template for untimely determination Service authorization log(s) within the time period under review Tracking and reporting mechanism(s) Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> HSAG will also use the data from the universe file HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> UM.017 Adverse Benefit Determination Policy page 6 UM.010 Decision Response Time page 2, procedure 5 and page 6 ACLA Untimely template pg 3 BITS screenshot STD VII ELM 22 ABD notice of untimely auth case example 1 STD VII ELM 22 ABD notice of untimely auth case 2 STD VII ELM 22 ABD notice of untimely auth case 3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Summary of Service Authorizations Workplan 	
<p>MCE Description of Process: The process to deny untimely determination is found in the provided policy UM.010 Decision Response time page 2. There is not a specific ABD notice template for untimely determinations. UM Staff utilize the BH-IP MED NEC FULL DENIAL TEMPLATE provided with element 19. This criterion is not addressed in the UM Program Description.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Compensation for Utilization Management Activities		
<p>23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right;">42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description New hire and ongoing training for staff Three examples of staff attestations <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 ACLA Utilization Management Program Description page 25 UM.003 Standard and Expedited Prior Authorization page 7 UM New Hire Sample 24-25 Completed Attestations ACLA 2024-2025 Compliance Training_Active Associates_Complete_4-17-25 2024-2025 COC, Ethics Attestation, and COI 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: UM staff do not receive incentives to deny, in whole or part, services requested. AmeriHealth Caritas provides Code of Ethics and Conduct training, which is completed by all new associates within their first 30 days of hire and annually thereafter. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Results for Standard VII—Coverage and Authorization of Services						
Total	Met	=	21	X	1	= 21
	Not Met	=	0	X	0	= 0
	Not Applicable	=	2			
Total Applicable		=	21	Total Score	=	21

Total Score ÷ Total Applicable	=	100%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
General Rules		
<p>1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214.</p> <p>MCO: For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff.</p> <p style="text-align: right;">42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Pages 4-9 • 552-020 Credentialing and Recredentialing Practitioner, Pages 4-9 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Policy and Procedure Provider Contracts 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Prospective network providers are required to complete a credentialing application and undergo initial credentialing and thereafter re-credentialing every three years.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA did not implement written policies and procedures for retention of network providers.</p>		
<p>Required Actions: The MCE must implement written policies and procedures for retention of network providers that at a minimum meet the requirements of 42 CFR §438.214.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types:</p> <ul style="list-style-type: none"> a. Acute; b. Primary; c. Mental health; d. Substance use disorders. <p style="text-align: right;">42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.101 Organization Provider Credentialing, Pages 4-9 • 552-022 Organizational Provider Credentialing and Recertification Process, Pages 4-9 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Prospective network providers are required to complete a credentialing application and undergo initial credentialing and thereafter re-credentialing every three years.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Nondiscrimination		
<p>3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12.</p> <p style="text-align: right;">42 CFR §438.214(c) 42 CFR §438.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Page 3 • 552-020 Credentialing and Recredentialing Practitioner, Page 4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 552-017 Credentialing Committee 1.28.2025 pg 2 • CP 210.104 CredRecred Practitioners RETIRED pg 20 • LA 2024 Annual Non-Discriminatory Report • 2024 TEMPLATE Non-Discriminatory Form • 2024 Policy and Procedure Provider Contracts, pg 6 	
<p>MCE Description of Process: Providers are invited to participate in the AmeriHealth Caritas Louisiana network based on their qualifications and an assessment and determination of the network's needs. Providers must be eligible to participate in Louisiana Medicaid in order to be credentialed with AmeriHealth Caritas regardless of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. Any Credentialing Committee decisions to deny and/or terminate providers are reviewed for any indication of discriminatory based decisions. Results of this review are reported to the Credentialing Committee.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>under applicable State law, solely on the basis of that license or certification.</p> <p>a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.</p> <p>b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214.</p> <p style="text-align: right;">42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17</p>	<ul style="list-style-type: none"> Examples of one individual and one organizational executed provider contracts Nondiscrimination statement for credentialing committee members Mechanism for monitoring for discriminatory practices HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Pages 3 552-020 Credentialing and Recredentialing Practitioner, Pages 4 2024 Template Non-discriminatory Form LA 2024 Annual Non-Discriminatory Report 159.302 Provider Contracts, pages 4 and 10 ACLA Ancillary Services Agreement, section 9.12, page ACLA Hospital Services Agreement, section 9.12, page ACLA Primary Care Provider Agreement, section 9.12, page ACLA Specialty Care Provider Agreement, section 9.12, page 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<p>Additional Documentation:</p> <ul style="list-style-type: none"> 552-025-Cred Recred Denial Termination, pgs 2-4, 8-9 CP210-103-Cred Recred Denial Termination, pgs 3-5, 8 Committee Term Letter Termination Letter-Provider Network Committee Denial Letter 	
<p>MCE Description of Process: Providers are invited to participate in the AmeriHealth Caritas Louisiana network based on their qualifications and an assessment and determination of the network's needs. Providers must be eligible to participate in Louisiana Medicaid in order to be credentialed with AmeriHealth Caritas regardless of licensure or certification. Any Credentialing Committee decisions to deny and/or terminate providers are reviewed for any indication of discriminatory based decisions. Results of this review are reported to the Credentialing Committee.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Excluded Providers		
<p>5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.</p> <p style="text-align: right;">42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3</p> <p>MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review 	
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Compliance Program Description, pgs.3 and 14-15. 552-003 Excluded Provider Monitoring, entire policy, ACLA references Pages 8-10 Monthly Sanction_Exclusion Screening of Providers Examples zip file 	
<p>MCE Description of Process: Each month, a new list of participating and non-participating providers are extracted from the claims system and sent to the Vendor for monitoring. Once they are uploaded in the Vendor’s system, the providers are monitored daily. Any provider identified as excluded or sanctioned by a Federal or State Agency is immediately terminated from the network.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
State Requirements		
<p>6. The MCE complies with any additional requirements established by the State.</p> <p>MCO:</p> <p>i. <i>The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Three consecutive months of attestations submitted to LDH HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p><i>that it has verified and confirmed that the provider is enrolled with the State.</i></p> <p>ii. <i>The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.</i></p> <p>iii. <i>The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]</i></p> <p>PIHP:</p> <p>a. <i>An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.</i></p> <p>b. <i>The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken</i></p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Compliance Program Description, page 15. • 148 ACLA 2024 07 • 148 ACLA 2024 08 • 148 ACLA 2024 09 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p><i>against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.</i></p> <p style="text-align: right;">42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4</p>		
<p>MCE Description of Process: AmeriHealth Caritas Louisiana conducts monthly screenings of providers, employees, and subcontractors and submits findings on the monthly 148 report attestation. Any identified matches are reported to LDH within three business days, as required.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Verification of Credentials		
<p>7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision.</p> <p>a. <i>The MCE verifies the license directly from the state licensing or certification agency (or its website).</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Page 11 • 552-020 Credentialing and Recredentialing Practitioner, Page 10 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies, directly from the state licensing or certification agency that the practitioner’s license is current, valid, in good standing and without restrictions or sanctions within required timeframes prior to the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Verification of Credentials		
<p>8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner’s Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>This requirement does not apply to practitioners who are not qualified to write prescriptions.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Page 12 552-020 Credentialing and Recredentialing Practitioner, Page 13 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies the existence of a current Federal DEA Certificate and/or Controlled Substances certificate at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision:</p> <p style="margin-left: 20px;">a. <i>Board certification;</i> b. <i>Residency; or</i> c. <i>Graduation from medical or professional school.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Page 11 552-020 Credentialing and Recredentialing Practitioner, Pages 10-11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies the practitioner’s highest level of education and training prior to the credentialing decision through NCQA approved sources.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. For credentialing and recredentialing, the MCE verifies the practitioner’s board certification status, if applicable, within 180 calendar days of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>Verification of board certification does not apply to nurse practitioners (NPs) or other health care professionals unless the MCO communicates board certification to members.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Page 12 552-020 Credentialing and Recredentialing Practitioner, Page 11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
MCE Description of Process: AmeriHealth Caritas Louisiana verifies the practitioner’s board certification status within required timeframes prior to the credentialing decision through NCQA approved sources.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>11. For credentialing, the MCE verifies the practitioner’s work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision.</p> <p>a. <i>If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.</i></p> <p>b. <i>If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner’s credentialing file.</i></p> <p>c. <i>If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Page 13 552-020 Credentialing and Recredentialing Practitioner, Page 12 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: AmeriHealth Caritas Louisiana verifies the practitioner’s work history and identifies gaps in employment within required timeframes prior to the credentialing decision through NCQA approved sources.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Page 12 • 552-020 Credentialing and Recredentialing Practitioner, Page 12 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies malpractice history and liability claims through a query of the National Practitioner Data Bank within required timeframes prior to the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Sanction Information		
<p>13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.</p> <p>a. <i>The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Page 13 • 552-020 Credentialing and Recredentialing Practitioner, Page 12 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies practitioner state sanctions, restrictions on licensure & limitations on scope of practice through a query of the National Practitioner Data Bank and through the Program Integrity Vendor which queries the System for Award Management and LA State Adverse Action list within required timeframes prior to the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.104 Credentialing Recredentialing of Practitioners, Page 12 552-020 Credentialing and Recredentialing Practitioner, Page 12 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: AmeriHealth Caritas Louisiana verifies Medicare and Medicaid sanctions through a query of the National Practitioner Data Bank and through the Program Integrity Vendor which queries the Office of Inspector General’s List of Excluded Individuals and Entities database within required timeframes prior to the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Practitioner Credentialing Application/Attestation		
<p>15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include:</p> <ol style="list-style-type: none"> a. <i>Reasons for inability to perform the essential functions of the position;</i> b. <i>Lack of present illegal drug use;</i> c. <i>History of loss of license and felony convictions;</i> d. <i>History of loss or limitation of privileges or disciplinary actions;</i> e. <i>Current malpractice insurance coverage; and</i> f. <i>Current and signed attestation confirming the correctness and completeness of the application.</i> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CP 210.104 Credentialing Recredentialing of Practitioners, Page 7 • 552-020 Credentialing and Recredentialing Practitioner, Page 6 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • ACLA acknowledges there is no evidence to submit responsive to this requirement. 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: All Practitioners must submit a signed/dated application and an attestation/release form. AmeriHealth Caritas Louisiana accepts applications submitted through the Council for Affordable Quality Healthcare (CAQH) or the Louisiana Standardized Credentialing Application.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s policy and procedure did not include language that the application and attestation included current malpractice insurance coverage, and a current and signed attestation confirming the correctness and completeness of the application. In addition, the documentation submitted for two initial credentialing practitioner case files did not verify compliance with current malpractice insurance coverage. The files contained self-reported malpractice insurance information within the application; however, evidence of current malpractice coverage obtained through verification was not included.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must revise policies and any other applicable documents to include language that states the application and attestation include current malpractice insurance coverage, and a current and signed attestation confirming the correctness and completeness of the application. Furthermore, credentialing files must include evidence of current malpractice coverage obtained through verification.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Practitioner Monitoring		
<p>16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by:</p> <p>a. <i>Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);</i></p> <p>b. <i>Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and</i></p> <p>c. <i>Implementing appropriate interventions when it identifies instances of poor quality.</i></p> <p style="text-align: right;">2 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider complaints tracking reports Provider adverse events tracking reports Credentialing committee meeting minutes Two examples of interventions taken based on poor quality of care <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Credentialing Committee Minutes QM 154.300 Potential Quality of Care Concerns – Medicaid 1-2024 2024 QOC Episode 49098910 2024 QOC Episode 49502607 Q1 2024 QAPI Meeting Minutes Q2 2024 QAPI Meeting Minutes Q3 2024 QAPI Meeting Minutes Q4 2024 QAPI Meeting Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: AmeriHealth Caritas Louisiana’s provider quality of care concern program is designed to monitor and improve the quality of healthcare services provided by its network of practitioners and facilities. The program aims to ensure members receive safe, effective, patient-centered, timely, efficient, and equitable care. Part of the program’s policy includes conducting regular reviews and oversight of providers. The program uses this information to identify areas for improvement, develop and implement corrective actions, and ultimately enhance the overall quality and safety of healthcare provided to members. A leveled provider tracker is emailed monthly to Provider Enrollment Services leaders for the Credentialing Committee. In addition, and per policy, all leveled cases are reported to QAPI Committee quarterly.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Organizational Verification of Credentials		
<p>17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of organizational provider types and corresponding licensing body in the State of Louisiana HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.101 Organizational Provider Credentialing, Page 6 552-022 Organizational Provider Credentialing and Recertification Process, Page 6-7 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Prospective network providers are required to complete a credentialing application and undergo initial credentialing which includes confirmation that the provider is in good standing with state and federal regulatory bodies.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.</p> <p>a. <i>If the provider is not accredited, the MCE conducts an onsite quality assessment.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Onsite assessment review tool/template HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>i. <i>The MCE has a process for ensuring that the provider credentials their practitioners.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CP 210.101 Organizational Provider Credentialing, Page 6 552-022 Organizational Provider Credentialing and Recertification Process, Page 6 Site Visit Tool TEMPLATE 031115 NHG <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA Credentialing Requirements Rev 7.3.2024 pg 2 Site Visit Tool TEMPLATE Staffing 	
<p>MCE Description of Process: Prospective network providers are required to complete a credentialing application and undergo initial credentialing, which includes confirmation that the provider has been reviewed by an accrediting body. If a provider is not accredited, ACLA conducts a site survey.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review did not verify compliance with the requirement. The on-site quality assessment tool submitted by ACLA included components of the credentialing procedures; however, it did not provide sufficient evidence that would confirm the provider had a comprehensive process in place for credentialing its providers.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must conduct an on-site quality assessment for a provider that is not accredited and must develop a process to ensure that the provider credentials its practitioners.</p>		
Time Frames		
<p>19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Recredentialing timeliness report during the review period HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health 2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> CP 210.101 Organizational Provider Credentialing, Page 11 552-022 Organizational Provider Credentialing and Recertification Process, Page 9 346 ACLA 2024 Q1 Resubmit 1 346 ACLA 2024 Q2 Replace 1 346 ACLA 2024 Q3 346 ACLA 2024 Q4 	
MCE Description of Process: Network providers are recertified every 36 months. Recertification includes re-confirmation of the provider's credentials.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one recertifying practitioner case file did not include evidence of the medical director or credentialing committee that reviewed and approved/denied the provider.		
Required Actions: The MCE must include, in each provider’s file, evidence of the recertifying decision made by the medical director or credentialing committee, and decisions must be documented and signed. In addition, the MCE must include evidence that it notifies providers of recertifying decisions (which is often within 60 days of committee decision).		

Results for Standard VIII—Provider Selection							
Total	Met	=	15	X	1	=	15
	Not Met	=	4	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	19	Total Score	=	15	

Total Score ÷ Total Applicable	=	79%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
General Rule		
<p>1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.</p> <p style="text-align: right;">42 CFR §438.230(b)(1) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 Delegation Oversight Policy 277.010 page 1 • CP 210 107 Delegation of Credentialing and Recredentialing Activities 2.28.2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA engages in subcontractor oversight and auditing to validate delegates are compliant with contractual requirements and issues corrective action notices where needed to mitigate any instances of risk.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Contract or Written Arrangement		
<p>2. Each contract or written arrangement with a delegate must specify:</p> <p>a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.</p> <p>b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE’s contract obligations.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • a: Delegated Services Agreement Template page 1 section II.A 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily.</p> <p style="text-align: right;"><i>42 CFR §438.230(b)(2)</i> <i>42 CFR §438.230(c)(1)</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3 PAHP Contract: 2.15.6.3; 2.15.9 PIHP Contract: 1.5.3.1</p>	<ul style="list-style-type: none"> b: Delegated Services Agreement Template page 2 paragraph 2 c: Delegated Services Agreement Template page 22 paragraph B a. LA Delegated Credentialing Agreement, Section 2, a-1; Exhibits A, B and D b. LA Delegated Credentialing Agreement, Section 2.b.iv, Exhibit A, Page 11 and Exhibit C c. LA Delegated Credentialing Agreement, Section 4, c-e 	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and</p> <p>MCO:</p> <p>a. <i>rules, policies, procedures, manuals, the State Plan, and Waivers.</i></p> <p style="text-align: right;"><i>42 CFR §438.230(c)(2)</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Delegated Services Agreement Template page 17 paragraph L.2; page 2 paragraph 2 LA Delegated Credentialing Agreement, Section 2.d 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: N/A		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA submitted its Delegated Services Agreement Template and LA Delegated Credentialing Agreement for review. HSAG also reviewed ACLA’s Delegation File Review to evaluate this element. While ACLA’s written agreements did evidence similar language, ACLA’s language did not comport with the required federal and State language of this requirement, which is exacting.</p>		
<p>Required Actions: The MCE must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and rules, policies, procedures, manuals, the State Plan, and Waivers.</p>		
<p>4. The contract or written arrangement indicates, and the delegate agrees that:</p> <p style="margin-left: 20px;">a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE’s contract with the State.</p> <p style="margin-left: 20px;">b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.</p> <p style="margin-left: 20px;">c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.</p> <p style="margin-left: 20px;">d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> a: LA Regulatory Exhibit Template page 6 paragraph d) b: LA Regulatory Exhibit Template page 7 paragraphs f) and f)i. c: LA Regulatory Exhibit Template page 7 paragraph f)ii. d: LA Regulatory Exhibit Template page paragraph f)iii. a. LA Delegated Credentialing Agreement, Section 2.k, Page 4 b. NA - Delegated Credentialing Agreement c. NA – Delegated Credentialing Agreement d. NA – Delegated Credentialing Agreement 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.</p> <p style="text-align: right;"><i>42 CFR §438.230(c)(3)</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1</p>		
MCE Description of Process: N/A		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA submitted its LA Regulatory Exhibit Template and LA Delegated Credentialing Agreement for review. HSAG also reviewed ACLA’s Delegation File Review to evaluate this element. While ACLA’s written agreements did evidence similar language, ACLA’s language did not comport with the required federal and State language of this requirement, which is exacting.</p>		
<p>Required Actions: The MCE must ensure that all contract or written arrangements indicate, and the delegate agrees that:</p> <ol style="list-style-type: none"> a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate’s subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE’s contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>5. The contract or written arrangement:</p> <p>MCO:</p> <p>a. <i>Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.</i></p> <p style="text-align: right;"><i>42 CFR §438.230</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> LA Regulatory Exhibit Template page 29 paragraph 45. LA Delegated Credentialing Agreement, Section 5.d 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Monitoring and Auditing		
<p>6. Monitoring subcontractor’s performance shall be monitored:</p> <p>MCO:</p> <p>a. <i>On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.</i></p> <p>PAHP:</p> <p>a. <i>On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template Monitoring and audit documentation Annual formal review HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Delegation Oversight Policy 277.010, page 4 paragraphs D and E 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>PIHP: a. <i>The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.</i></p> <p style="text-align: right; margin-right: 100px;"><i>42 CFR §438.230</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3</p>	<ul style="list-style-type: none"> • Delegated Services Agreement Template, page 8 paragraph K and page 39 paragraph 16A • BHM Executive Summary LA 2024 • Carenet Executive Summary LA 2024 • Merakey Annual Executive Summary LA 2024 • NIA Executive Summary LA 2024 • Prime Executive Summary LA 2024 • PRx Executive Summary LA 2024 • Somatus Executive Summary LA 2024 • Via Link Executive Summary LA 2024 • Delegated Credentialing Agreement, Section 3 • LA FMOL 2024 Cred Executive Summary • LA HSNL 2024 Cred Executive Summary • LA LSUNO 2024 Cred Executive Summary • LA Ochsner 2024 Cred Executive Summary • LA Ochsner LSU 2024 Cred Executive Summary • PSG 2024 Cred Executive Summary • LA SLMA Cred Executive Summary • LA St Jude Children’s Hospital 2024 Cred Executive Summary • LA TCPSO 2024 Cred Executive Summary • LA TCUC 2024 Cred Executive Summary • LA Tulane 2024 Cred Executive Summary • LA WKHS 2024 Cred Executive Summary 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
MCE Description of Process: ACLA engages in subcontractor oversight and auditing to validate delegates are compliant with contractual requirements and issues corrective action notices where needed to mitigate any instances of risk.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	4	X	1	=	4
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	Total Score		=	4

Total Score ÷ Total Applicable	=	67%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
Adoption of Practice Guidelines		
<p>1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.</p> <p style="text-align: right;">42 CFR §438.236(b)(1) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 391.1001-Clinical Policy Committee (Admin Policy) • 391.1003 - Corp Clinical Policy Preventative Clinical Practice Guidelines 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Topics for Corporate Clinical Practice Guidelines (CPG) are researched and compiled into a list for review and approval by an internal committee, the Corporate Clinical Policy Committee. Upon approval, the list of CPGs is sent to the ACLA QAPI for review, approval, and adoption. The QAPI meeting minutes are submitted to LDH via quarterly report 119, for review and approval. Upon approval, the list is published on the ACLA public-facing website.</p>		
<p>HSAG Finding: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE adopts practice guidelines that consider the needs of the MCE’s members and:</p> <p>MCO:</p> <p style="padding-left: 20px;">a. adopts clinical practice guidelines for at least the conditions listed below:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> i. Schizophrenia; ii. Attention Deficit Hyperactivity Disorder (ADHD); iii. Autism Spectrum Disorder; iv. Depression; v. Generalized Anxiety Disorder; vi. Post-Traumatic Stress Disorder; vii. Suicidal Behavior; viii. Oppositional Defiant Disorder; ix. Bipolar Disorder; and x. Substance Use Disorders. <p>PIHP:</p> <ul style="list-style-type: none"> a. develops clinical practice guidelines for: <ul style="list-style-type: none"> i. ADHD ii. Trauma Informed Care iii. Depression and Conduct Disorder <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(b)(2) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 391.1001-Clinical Policy Committee (Admin Policy) • 391.1003 - Corp Clinical Policy Preventative Clinical Practice Guidelines • Corporate Clinical Practice Guidelines, entire document 	
<p>MCE Description of Process: Topics for Corporate Clinical Practice Guidelines (CPG) are researched and compiled into a list for review and approval by an internal committee, the Corporate Clinical Policy Committee. Topics include the needs of ACLA members and input is provided by ACLA Medical Director and ACLA Behavioral Health Medical Director. The CPGs include, at a minimum, the conditions identified in 2a.</p>		
<p>HSAG Finding: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>3. The MCE adopts practice guidelines that are adopted in consultation with network providers.</p> <p style="text-align: right;">42 CFR §438.236(b)(3) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 391.1001-Clinical Policy Committee (Admin Policy) • 391.1003 - Corp Clinical Policy Preventative Clinical Practice Guidelines • Corporate Clinical Practice Guidelines • ACLA QAPI Committee 2024 Q4 • January 2024 CPC Meeting Minutes • February 2024 CPC Meeting Minutes • March 2024 CPC Meeting Minutes • April 2024 CPC Meeting Minutes • May 2024 CPC Meeting Minutes • June 2024 CPC Meeting Minutes • July 2024 CPC Meeting Minutes • August 2024 CPC Meeting Minutes • September 2024 CPC Meeting Minutes • October 2024 CPC Meeting Minutes • November 2024 CPC Meeting Minutes • December 2024 CPC Meeting Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
MCE Description of Process: ACLA Network Providers are voting members on the QAPI committee, where CPGs are reviewed and voted upon.		
HSAG Finding: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>4. The MCE adopts practice guidelines that are:</p> <p>MCO/PAHP:</p> <p style="margin-left: 20px;">a. reviewed and updated periodically as appropriate.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. Reviewed annually and updated periodically as appropriate.</p> <p style="margin-left: 20px;">b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(b)(4) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract: 7.4.5.4; 7.4.7.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 391.1001-Clinical Policy Committee (Admin Policy) 391.1003 - Corp Clinical Policy Preventative Clinical Practice Guidelines CPG-ACLA-0824 CPG-ACLA-V24-11 CPG-ACLA-0224 CPG-ACLA24-05 January 2024 CPC Meeting Minutes February 2024 CPC Meeting Minutes March 2024 CPC Meeting Minutes April 2024 CPC Meeting Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> May 2024 CPC Meeting Minutes June 2024 CPC Meeting Minutes July 2024 CPC Meeting Minutes August 2024 CPC Meeting Minutes September 2024 CPC Meeting Minutes October 2024 CPC Meeting Minutes November 2024 CPC Meeting Minutes December 2024 CPC Meeting Minutes 119 ACLA 2024 Q1 119 ACLA 2024 Q2 119 ACLA 2024 Q3 119 ACLA 2024 Q4 	
MCE Description of Process: CPGs are reviewed annually and submitted to LDH for approval via quarterly report 119.		
HSAG Finding: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Dissemination of Guidelines		
5. The MCE disseminates the guidelines to: <ul style="list-style-type: none"> a. All affected providers b. Members and potential members, upon request <ul style="list-style-type: none"> 42 CFR §438.236(c) 42 CFR §457.1233(c) MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL.pdf, page 35 • 2024 Member HB English Version_Audit, page 40 	
MCE Description of Process: Updated CPGs are loaded onto ACLA’s website, which is accessible to all providers and members.		
HSAG Finding: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Application of Guidelines		
<p>6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p style="text-align: right;">42 CFR §438.236(d) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None</p>	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and procedures • Coverage guidelines/criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • UM.708 Inter-Rater Reliability Policy, Page 1, Policy Section • UM.008 Utilization Management Clinical Criteria Policy, Page 1, Policy Section; Page 10 AmeriHealth Caritas Louisiana Clinical Criteria • ABD Notice case example #1 • ABD Notice case example #2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> ABD Notice case example #3 	
<p>MCE Description of Process: ACLA’s utilization management criteria are based on a hierarchy of clinical criteria to be used in medical necessity determinations. Approved CPGs are included in the hierarchy and utilized as applicable.</p>		
<p>HSAG Finding: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard X—Practice Guidelines							
Total	Met	=	6	X	1	=	6
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	Total Score	=	6	

Total Score ÷ Total Applicable	=	100%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
General Rule		
<p>1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to:</p> <ul style="list-style-type: none"> a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. <p style="text-align: right;">42 CFR §438.242(a) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 532-015 - Disenrollment and Enrollment Process • 178.001.EDM Encounters General Operating Policy – entire policy • Encounters Policies and Procedures LA 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> ACLA 2024 LA_NAV_ISCAT_Final ACLA Provider Handbook for December 2024-FINAL ACFC Data Architecture Enrollment and Eligibility Processing Diagram Population Health Transaction Flow.jpg Provider Network Management Transaction Flow System Companion Guide List of Disenrollment Reasons and Closure Codes Facets Screenshots of disenrollment codes and closure codes 	
<p>MCE Description of Process: Our Health Information systems collect, analyze, integrate, and report data, and can achieve the objectives of Medicaid managed care requirements. For process descriptions, please see the individual documents provided.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Basic Elements of a Health Information System		
<p>2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State.</p> <p style="text-align: right;">42 CFR §438.242(b)(2) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Claims data collection and processing guidelines Encounter data collection and submission guidelines HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACFC Data Architecture • 531-036 - Processing and Prompt Payment of Claims - Louisiana • 178.001.EDM Encounters General Operating Policy • Encounters Policies and Procedures LA • 178.016 Encounters Performance Monitoring • 178.010 Encounters Subcontractor Monitoring • 178.015 Encounter Error Resolution Process <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 178.016 Encounters Performance Monitoring • 178.015 Encounter Error Resolution Process 	
<p>MCE Description of Process: Citations referencing basic elements of a health information system are supported through our core benefits-administration platform, TriZetto Facets®, and by the core benefits-administration platforms of subcontracted vendors. All relevant data (Member, Provider & Claim) is loaded into the EDM database from the Facets Health Benefits System. Data includes member eligibility information, provider identifying information, service, and treatment (encounters) data submitted to ACFC by providers, paid claims, and encounter data files received from subcontractors. Data from Subcontractors performing value-added services (e.g., Dental, Vision) are loaded into EDM Staging Tables. Pharmacy claims are adjudicated by an automated point-of-sale processing system managed by the PBM subcontractor and loaded into ACFC pharmacy data warehouse for further encounter processing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>3. The MCE ensures that data received from providers is accurate and complete by:</p> <ul style="list-style-type: none"> a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. <p style="text-align: right;">42 CFR §438.242(b)(3) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Claims Filing Instructions - page 6 • 159.302 Provider Contracts page 12 • Provider Handbook page 32 • 531-036 - Processing and Prompt Payment of Claims - Louisiana • 122-006 - Formal Claims Auditing Process • Claim Timeliness Reports <p>Additional Documentation:</p> <ul style="list-style-type: none"> • ACLA Claims Filing Instructions.pdf 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The Data Warehouse receives claim data from FACETS. We refresh the Data Warehouse daily and have a balancing process in place to ensure we match to FACETS.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>4. The MCE makes all collected data available to the State and upon request to CMS.</p> <p style="text-align: right;">42 CFR § 438.242(b)(4) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 178.001.EDM Encounters General Operating Policy Claim Transaction Flow Encounters Policies and Procedures LA 178.016 Encounters Performance Monitoring 178.010 Encounters Subcontractor Monitoring 178.015 Encounter Error Resolution Process 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: We submit Encounter data to the state Medicaid agency in the standard format according to the submission time schedule set by the Medicaid agency. Within state-specified timeframes, ACFC will also review, research, and correct Encounter data that the Medicaid agency rejects or returns as an error. See the individual policies and procedures for a description of each process' steps.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Claims Processing		
<p>5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Claims data collection and processing guidelines 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission).</p> <p style="text-align: right;">42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F)</p> <p>MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7</p>	<ul style="list-style-type: none"> HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 531-036 - Processing and Prompt Payment of Claims – Louisiana Claim Transaction Flow ACFC Data Architecture 	<input type="checkbox"/> NA
<p>MCE Description of Process: The Data Warehouse receives claim data from FACETS. We refresh the Data Warehouse daily and have a balancing process in place to ensure we match to FACETS.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Application Programming Interface		
<p>6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members’ personal representatives through the API as follows:</p> <p>a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed;</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. List of registered third-party applications HSAG will use the results from the API demonstration <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACFC Data Architecture 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments;</p> <p>c. All other encounter data, including adjudicated claims and encounter data from any subcontractors.</p> <p>d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE;</p> <p>e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information.</p> <p style="text-align: right;">42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<ul style="list-style-type: none"> ACFC - CMS Interoperability Authorization slides - End to end flow 2100-LA Interoperability Rule Patient Access API Member Education and Consent Summary Walkthrough and Visualization LDH_MCE_Compliance_Plan 178.001.EDM Encounters General Operating Policy – entire policy 178.016 Encounters Performance Monitoring 178.010 Encounters Subcontractor Monitoring 178.015 Encounter Error Resolution Process 	
<p>MCE Description of Process: A member can use an approved application to access their data held by AmeriHealth Caritas.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the MCO’s website.</p> <p style="text-align: right;">42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.13.2.3 PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6 PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20</p>	<ul style="list-style-type: none"> List of registered third-party applications HSAG will use the results from the web-based provider directory demonstration <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACFC Data Architecture ACFC - CMS Interoperability Authorization slides - End to end flow 2100-LA Interoperability Rule Patient Access API Member Education and Consent Summary Walkthrough and Visualization LDH_MCE_Compliance_Plan 	
<p>MCE Description of Process: An unauthenticated API that lists all participating providers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendations: HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p>Required Actions: No action required.</p>		
Member Encounter Data		
<p>8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.</p> <p style="text-align: right;">42 CFR §438.242(c)(1) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Encounter data collection requirements Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health 2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
PIHP Contract: 15.2.2.3; 15.2.2.9	<ul style="list-style-type: none"> HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 178.001.EDM Encounters General Operating Policy 178.016 Encounters Performance Monitoring 178.010 Encounters Subcontractor Monitoring 178.015 Encounter Error Resolution Process Screenshots of encounter data with rendering and paid amounts – See Medical professional example 	
<p>MCE Description of Process: All relevant data (Member, Provider & Claim) is loaded into the EDM database from the Facets Health Benefits System. Data includes member eligibility information, provider identifying information, service, and treatment (encounters) data submitted to ACFC by providers, paid claims, and encounter data files received from subcontractors. Data from Subcontractors performing value-added services (e.g., Dental, Vision) are loaded into EDM Staging Tables. Pharmacy claims are adjudicated by an automated point-of-sale processing system managed by the PBM</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs.</p> <p>a. The member encounter data includes all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Encounter data submission requirements Three concurrent months/quarters of submission compliance (acceptance/rejection reports) Two samples/screenshots of encounter data with allowed amount and paid amount fields (one 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.</p> <p>MCO:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH</i></p> <p>PAHP:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly.</i></p> <p>PIHP:</p> <p>a. <i>Submit complete and accurate encounter data at least weekly</i></p> <p style="text-align: right;">42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1</p>	<p>sample must include encounter data from a sub-capitated source)</p> <ul style="list-style-type: none"> HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 178.001.EDM Encounters General Operating Policy – entire policy 178.016 Encounters Performance Monitoring 178.010 Encounters Subcontractor Monitoring 178.015 Encounter Error Resolution Process Screenshots of encounter data with rendering and paid amounts, example of SouthEastern Trans as subcap provider LA Encounter Report - ACLA July 2024 FINAL LA Encounter Report - ACLA May 2024 FINAL LA Encounter Report - ACLA November 2024 FINAL 	
<p>MCE Description of Process: We submit Encounter data to the state Medicaid agency in the standard format according to the submission time schedule set by the Medicaid agency. Within state-specified timeframes, Encounter data elements, required formats, and other pertinent Encounter reporting requirements, are documented in the State issued MCO Systems Companion Guide. Specific processes and procedures documentation which further describes processes for ensuring timely, complete, and accurate data in required formats. Encounters Files are built from EDM and put into a standard ANSI x12 EDI 837 format (Professional, Institutional, or Dental) based on the Facets claim type. Pharmacy encounters are formatted into industry-standard NCPDP files.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Results for Standard XI—Health Information Systems						
Total	Met	=	9	X	1	= 9
	Not Met	=	0	X	0	= 0
	Not Applicable	=	0			
Total Applicable		=	9	Total Score	=	9

Total Score ÷ Total Applicable	=	100%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
General Rules		
<p>1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members.</p> <p style="text-align: right;">42 CFR §438.330(a)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • QAPI program work plan • QAPI 2024 program description • Quality Improvement Policy 154.201 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: A comprehensive QAPI program is established by implementing a systematic approach, combining quality and performance improvement activities. The program aims to improve the quality and appropriateness of care for all members, including those with special needs. Key components include performance measurement, performance improvement projects (PIPs), tools to identify under- and overutilization, and processes for assessing care quality. The program also integrates with state quality strategies and undergoes external quality reviews.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Basic Elements of QAPI Programs		
<p>2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services.</p> <p style="text-align: right;">42 CFR §438.330(b)(3) 42 CFR §457.1240(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	<ul style="list-style-type: none"> QAPI program evaluation Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> QAPI 2024 program description QAPI Program Work Plan QAPI program evaluation Quality Improvement Policy 154.201 QCCC Quarterly ER Utilization Reports QCCC Quarterly KPI Over and Under Utilization Reports QCCC Meeting Minutes <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA 2024 QI Evaluation Q2 Update QCCC Q1 KPI_Over Under Utilization Report QCCC Q2 KPI_Over Under Utilization Report QCCC Q3 KPI_Over Under Utilization Report QCCC Q4 KPI_Over Under Utilization Report 	
<p>MCE Description of Process: ACLA performs baseline utilization measurements to calculate inpatient admission rates and length of stay; emergency room utilization rates; and clinical guideline adherence for preventive health and chronic illness management services to identify those</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>areas that fall outside the expected range to assess for over- or underutilization. Findings and recommendations will be reviewed by the QAPI Committee for prioritization and action.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy.</p> <p style="text-align: right;">42 CFR §438.330(b)(4) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 391.1003 - Corp Clinical Policy Preventative Clinical Practice Guidelines • List of Clinical Practice Guidelines CPG-ACLA-v25-02 • QAPI program work plan • QAPI 2024 program description • Population Health Management Program Strategy 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Population Health Assessment Report Quality Improvement Policy 154.201 <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA 2024 QI Evaluation Q2 Update 	
<p>MCE Description of Process: <u>Clinical Guidance/Criteria:</u> Topics for Corporate Clinical Practice Guidelines (CPG) are researched and compiled into a list for review and approval by an internal committee, the Corporate Clinical Policy Committee. Upon approval, the List of CPGs is sent to the ACLA QAPIC for review and approval of adoption. Upon QAPIC approval, the List is published to the ACLA public-facing website. ACLA analyzes population health data by key special populations, including specific eligibility categories or program classifications such as members with special health care needs. To assess the quality and appropriateness of care furnished to members with special health care needs, we review population-specific reports through quality management committees to monitor access to high-quality, person-centered care and help ensure that each population has access to entitled benefits, Care Coordination services, and supports. We perform drill-down analysis and convene stakeholders to address barriers as they arise.</p> <p>All members with Special Health Care Needs are identified, assessed and outreached to offer CM services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including:</p> <ol style="list-style-type: none"> a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member’s treatment/service plan, if applicable. <p style="text-align: right;">42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b)</p> <p>MCO Contract: NA PAHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Assessment tools Clinical guidance/criteria Metrics/performance measures to assess LTSS Medical record audit tools and results 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
PIHP Contract: NA	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • NA 	
MCE Description of Process: NA		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Performance Measurement		
<p>5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually:</p> <ol style="list-style-type: none"> a. Measures and reports to the State on its performance, using the standard measures required by the State; b. Submits to the State data, specified by the State, which enables the State to calculate the MCO’s performance using the standard measures identified by the State; or c. Performs a combination of the activities described in subelements (a) and (b). <p style="text-align: right;">42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1</p>	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Performance measures reports • Evidence of submission of performance measurement reports to the State Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • QAPI program work plan • QAPI 2024 program description • Quality Improvement Policy 154.201 • QAPI program evaluation • AHLA Medicaid HEDIS Bulk Download • AHLA FAR MY 2023 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Auditor’s Final Audit Report for AmeriHealth Caritas Louisiana Email Confirmation June 14th Deliverables Email Confirmation to LDH and HSAG <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA 2024 QI Evaluation Q2 Update 	
<p>MCE Description of Process: The process of collection and submission of performance measurement data involves use of diverse data sources, internal and external data validation, and submission to both the Louisiana Department of Health (LDH) and the National Committee for Quality Assurance (NCQA).</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Performance Improvement Projects		
<p>6. The QAPI program includes performance improvement projects (PIPs).</p> <p>a. The MCE conducts PIPs that focus on both clinical and nonclinical areas.</p> <p>MCO:</p> <p>a. <i>The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall perform a minimum of one LDH approved PIP.</i></p> <p style="text-align: right;">42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation List of all active PIPs, including which PIPs are considered clinical and non-clinical Documentation for all active PIPs <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> QAPI program work plan QAPI 2024 program description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2</p>	<ul style="list-style-type: none"> Quality Improvement Policy 154.201 QM 154.401 PIP Policy – December 2024 QAPI program evaluation BH TOC Zip file CCS Zip file CS Zip file FVA Zip file HIV Zip file <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA 2024 QI Evaluation Q2 Update 	
<p>MCE Description of Process: The QAPI program includes PIPs designed to address specific areas of concern identified through performance measurement and analysis, with the goal of achieving measurable positive change in health outcomes and member satisfaction. ACLA participated in five state approved PIPs, in 2024, including one behavioral health PIP.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements:</p> <ol style="list-style-type: none"> a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> QAPI program description QAPI program work plan QAPI program evaluation Policies and procedures Documentation for all active PIPs 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State.</p> <p>d. Planning and initiation of activities for increasing or sustaining improvement.</p> <p style="text-align: right;">42 CFR §438.330(d)(2) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • QAPI program work plan • QAPI 2024 program description • Quality Improvement Policy 154.201 • QM 154.401 PIP Policy – December 2024 • QAPI program evaluation • BH TOC Zip file • CCS Zip file • CS Zip file • FVA Zip file • HIV Zip file <p>Additional Documentation:</p> <ul style="list-style-type: none"> • ACLA 2024 QI Evaluation Q2 Update 	
<p>MCE Description of Process: The Plan designs improvement projects that aim to implement real, sustained and significant improvements in care and service by continuously measuring and thoroughly analyzing performance and developing and implementing appropriate system-wide improvements. Improvement strategies are designed to change behavior at an institutional, practitioner or member level. The effectiveness of intervention activities is determined by measuring change in performance, according to predefined quality indicators. If repeat measures indicate that quality improvement activities are not successful, i.e., did not achieve significant improvement, the problem-solving process begins again with data analysis to identify possible causes and to propose and implement solutions. If quality improvement activities are successful, the new processes are standardized and monitored.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year.</p> <p style="text-align: right;">42 CFR §438.330(d)(3) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Evidence of annual submission of all PIPs to the State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Quality Improvement Policy 154.201 • QM 154.401 PIP Policy – December 2024 • BH TOC Zip file • CCS Zip file • CS Zip file • FVA Zip file • HIV Zip file • AmeriHealth Caritas Louisiana Final PIP Submission 3.15.2024 Email Proof • PIP Reports 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Quality Management submits completed State/EQRO mandated PIPs to the State regulatory agency and/or EQRO entity as required.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Critical Incidents		
<p>9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h).</p> <p style="text-align: right;">42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2</p>	<ul style="list-style-type: none"> QAPI program evaluation Three examples of critical incident reports Committee meeting minutes Provider remediation plan template(s) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> QAPI program work plan QAPI 2024 program description Quality Improvement Policy 154.201 QAPI program evaluation QCCC Quarterly Adverse Incident Reports AIRs to QOCs (358 Report) QCCC Meeting Minutes QSC Meeting Minutes Provider Adverse Incident Reporting Policy QM 154.300 Potential Quality of Care Concerns Medicaid Policy Page 1 ACLA Provider CAP Letter Template 	
<p>MCE Description of Process: AmeriHealth Caritas Louisiana contributes to ensuring the safety, well-being, and high-quality care for members receiving services through waiver programs by implementing a robust QAPI program and actively participating in state-led incident management efforts. Participation is mandated by federal regulations and is consistent with the state's responsibilities for HCBS waiver programs. State involvement includes establishing standards, providing guidance and support, oversight, collaboration and ensuring accountability. The QAPI program participates in state efforts, and reports, investigates, tracks, and trends critical incidents.</p>		
<p>HSAG Findings: Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
QAPI Program Reviews, Analysis, and Evaluation		
<p>10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:</p> <p style="margin-left: 20px;">a. The performance on the measures on which it is required to report.</p> <p style="margin-left: 20px;">b. The outcomes and trended results of each PIP.</p> <p style="margin-left: 20px;">c. The results of any efforts to support community integration for members using LTSS.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.</i></p> <p style="margin-left: 40px;">42 CFR §438.330(e) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3 PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Committee meeting minutes (with discussion of QAPI evaluation) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> QAPI Committee Minutes (Q1 and Q2 includes QAPI Eval discussion) <p>Additional Documentation:</p> <ul style="list-style-type: none"> ACLA 2024 QI Evaluation Q2 Update 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The ACLA Quality Management (QM) program provides a framework for the evaluation of the delivery of health care, behavioral healthcare and services provided to members. The QM program description describes the quality improvement scope, goals, objectives, structure, and function for the plan. ACLA uses the scientific methods of continuous quality improvement to design, implement, operate, evaluate and improve services for its members. The QM program is evaluated as needed and at least annually to measure its effectiveness. The evaluation assesses all aspects of the QM program, including clinical performance and PIPs; quality studies and activities; and the rationale, methodology, results and subsequent improvement associated with each study. The evaluation includes trending of measures to assess performance in the quality and safety of clinical care and quality of service. Included is an analysis of the QM program’s effectiveness and progress toward influencing network-wide safe clinical practices.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>11. QAPI Committee Requirements:</p> <p>MCO:</p> <p>a. <i>The MCO forms a QAPI Committee that at a minimum includes:</i></p> <p style="margin-left: 20px;">i. <i>The MCO's Medical Director who must serve as either the chairman or co-chairman;</i></p> <p style="margin-left: 20px;">ii. <i>The MCO's Behavioral Health Director;</i></p> <p style="margin-left: 20px;">iii. <i>Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;</i></p> <p style="margin-left: 20px;">iv. <i>Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and</i></p> <p style="margin-left: 20px;">v. <i>An Enrollee representative(s) and/or advocate(s).</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall form a QAPI Committee that shall, at a minimum include:</i></p> <p style="margin-left: 20px;">i. <i>The Dental Director who must serve as either the chairman or co-chairman;</i></p> <p style="margin-left: 20px;">ii. <i>Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and</i></p> <p style="margin-left: 20px;">iii. <i>The PAHP shall include an enrollee advocate representative on the QAPI Committee.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall form a QAPI committee that shall, at a minimum include:</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • QAPI committee meeting minutes <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • QAPI committee minutes • QAPI Charter <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Member Advocate on Meeting Minutes (no attendance): <ul style="list-style-type: none"> – ACLA Q1 2024 QAPI Meeting Minutes – ACLA Q2 2024 QAPI Meeting Minutes – ACLA Q3 2024 QAPI Meeting Minutes – ACLA Q4 2024 QAPI Meeting Minutes • Online QAPI Member Info - https://www.amerihhealthcaritasla.com/member/info/quality 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>i. <i>The PIHP’s Medical Director, who must serve as the chair or co-chair and</i></p> <p>ii. <i>Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.</i></p> <p>MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1</p>		
<p>MCE Description of Process: ACLA has the following QAPI Membership requirements:</p> <ul style="list-style-type: none"> • Six to eight practicing Practitioners (Specialists and Primary Care Practitioners) • Market President, co-Chair • Director, Quality Management • Corporate Medical Director, Utilization Management • Medical Director, Utilization Management • Medical Director, Behavioral Health • Behavioral Health Coordinator • Director, Compliance and Regulatory Affairs • Director, Market Clinical Population Health, Care Coordination and Case Management • Director, Provider Network Management • Director, Plan Operations and Administration • Director, Pharmacy • Director, Community Education • Manager, Utilization Management / Medical Management Coordinator • Member Advocate Representative * • LDH Representative * 		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>12. QAPI Committee Responsibilities:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:</i></p> <p>i. <i>Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;</i></p> <p>ii. <i>Ensure that QAPI activities take place throughout the MCO’s organization and ensure that providers are involved in the QAPI Program;</i></p> <p>iii. <i>Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;</i></p> <p>iv. <i>Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;</i></p> <p>v. <i>Designate evaluation and study design procedures;</i></p> <p>vi. <i>Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;</i></p> <p>vii. <i>Report findings to appropriate executive authority, staff, and departments within the MCO’s organization;</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI committee meeting minutes • Evidence of submission to the State • Evidence of working with other Contractor staff and Subcontractors • Evidence of updates to the Provider Manual • Evidence of provider network performance reviews • Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members’ service utilization patterns <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Quality Improvement Policy 154.201 • Statutory Reports 119 • Quarterly Medical Record Review Reports • Statutory Report PQ069 • Quarterly Provider Monitoring Summary Reports • Quarterly Quality of Care Reports • ACLA Provider Handbook for December 2024 • Provider Performance Reports Zip File 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>viii. <i>Direct and analyze periodic reviews of Enrollees' service utilization patterns;</i></p> <p>ix. <i>Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;</i></p> <p>x. <i>Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;</i></p> <p>xi. <i>Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;</i></p> <p>xii. <i>Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and</i></p> <p>xiii. <i>Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.</i></p> <p>PAHP:</p> <p>a. <i>The QAPI Committee shall:</i></p> <p style="padding-left: 20px;">i. <i>Meet on a quarterly basis;</i></p> <p style="padding-left: 20px;">ii. <i>Direct and review quality improvement (QI) activities;</i></p>	<ul style="list-style-type: none"> • Provider Report Cards Zip File • 2024 QAPI Charter • QM 154.300 Potential Quality of Care Concerns Medicaid Policy 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> iii. <i>Ensure that QAPI activities are implemented throughout the PAHP;</i> iv. <i>Review and suggest new and/or improved QI activities;</i> v. <i>Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;</i> vi. <i>Designate evaluation and study design procedures;</i> vii. <i>Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;</i> viii. <i>Report findings to appropriate executive authority, staff, and departments within the PAHP;</i> ix. <i>Direct and analyze periodic reviews of enrollees' service utilization patterns;</i> x. <i>Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and</i> xi. <i>Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>QAPI committee responsibilities shall include:</i> <ul style="list-style-type: none"> i. <i>Directing and reviewing QI activities;</i> ii. <i>Ensuring that QAPI activities take place throughout the organization;</i> iii. <i>Suggesting new and/or improved QI activities;</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>iv. <i>Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;</i></p> <p>v. <i>Conducting provider quality performance measure profiling;</i></p> <p>vi. <i>Reporting findings to appropriate executive authority, staff, and departments within the PIHP;</i></p> <p>vii. <i>Directing and analyzing periodic reviews of members' service utilization patterns; and</i></p> <p>viii. <i>Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.</i></p> <p>MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2</p>		
<p>MCE Description of Process: The ACLA QAPI Committee oversees ACLAs efforts to measure, manage and improve quality of care and services delivered to ACLA members, and evaluate the effectiveness of the QAPI Program. The QAPIC directs and reviews ACLA's Quality Improvement, Integrated Healthcare Management, Utilization Management and Behavioral Health activities. The QAPI Committee provides oversight of the Quality of Clinical Care Committee (QCCC) and the Quality of Service (QSC).</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>13. QAPI Plan Requirements:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.</i></p> <p>b. <i>The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.</i></p> <p>c. <i>The QAPI Plan, at a minimum, shall:</i></p> <p style="margin-left: 20px;">i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i></p> <p style="margin-left: 20px;">ii. <i>Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;</i></p> <p style="margin-left: 20px;">iii. <i>Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;</i></p> <p style="margin-left: 20px;">iv. <i>Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;</i></p> <p style="margin-left: 20px;">v. <i>Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and</i></p> <p style="margin-left: 20px;">vi. <i>Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> QAPI Plan QAPI Program Description Evidence of submission to the State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> QAPI program work plan QAPI 2024 program description Quality Improvement Policy 154.201 QAPI program evaluation Statutory Report 136 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.</i> b. <i>The QAPI plan shall be submitted to LDH annually, and prior to revisions.</i> c. <i>The QAPI plan, at a minimum, shall:</i> <ul style="list-style-type: none"> i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i> ii. <i>Include processes to evaluate the impact and effectiveness of the QAPI Program;</i> iii. <i>Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and</i> iv. <i>Describe the role of providers in giving input to the QAPI Program.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of Behavioral Health, Louisiana Department of Health (OBH).</i> b. <i>The QAPI program description at a minimum, shall:</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> i. <i>Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.</i> ii. <i>Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.</i> iii. <i>Specify the remediation actions that will be implemented when system performance is less than the required threshold.</i> iv. <i>Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention’s effectiveness.</i> v. <i>Describe how the Contractor will obtain feedback from providers and members.</i> vi. <i>Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.</i> vii. <i>Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>c. <i>The QAPI work plan at a minimum shall:</i> <i>Include objectives for the Contract year, inclusive of associated action steps and timelines.</i></p> <p>i. <i>Include metrics and associated benchmarks for the wraparound agency scorecard.</i></p> <p>ii. <i>Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.</i></p> <p>iii. <i>Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator’s (WF) demonstration of established wraparound competencies on a quarterly basis.</i></p> <p>MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: ACLA develops a QAPI Work Plan annually with quarterly updates. The Work Plan incorporates contract requirements and is supported by the QAPI Program Description and Evaluation. The Quality Management Program activity is reported throughout the year to the QAPI Committee. Activity and outcomes are reported using internal tools in addition to the reporting tools and specifications required by the State and NCQA. The QAPI Work Plan, Program Description, and Evaluation are submitted to LDH annually.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard XII—Quality Assessment and Performance Improvement						
Total	Met	=	11	X	1	= 11
	Not Met	=	0	X	0	= 0
	Not Applicable	=	2			
Total Applicable		=	11	Total Score	=	11

Total Score ÷ Total Applicable	=	100%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievance System General Requirements		
<p>1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 131.201 Member Grievances 2024.docx page 3 • 2024 Member HB English Version_Audit page 53 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA identifies, tracks and resolves any expression of dissatisfaction about any matter other than an adverse benefit determination. The Contact Center Representative receives, records, and initiates the resolution process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>2. A member may file a grievance with the MCE at any time.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Member consent form template HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 131.201 Member Grievances 2024.docx page 4, 7 2024 Member HB English Version_Audit page 53 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA accepts oral or written communication from the member and there is no timeframe to file a grievance. An authorized representative acting on the member’s behalf, or a network provider acting on the member’s behalf can contact Member Services at any time. ACLA does not have a standardized member consent form template, as written consent is not a requirement, and we will accept any written consent submitted.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The member may file a grievance either orally or in writing.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook HSAG will also use the results of the system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 131.201 Member Grievances 2024.docx page 4 2024 Member HB English Version_Audit page 53 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
MCE Description of Process: ACLA’s Contact Center Representative receives, records and initiates the resolution process. ACLA accepts oral or written communication from the member and there is no timeframe to file a grievance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Grievances		
<p>4. The MCE acknowledges receipt of each grievance.</p> <p>MCO and PAHP:</p> <p>a. <i>The MCO’s/PAHP’s process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.</i></p> <p>PIHP:</p> <p>a. <i>Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Grievance acknowledgment notice template Tracking and reporting mechanisms HSAG will also use the results of the Grievances File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 131.201 Member Grievances 2024.docx page 5 Grievance Tracking and Reporting.xlsx Grievance Acknowledgment Notice.docx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The Grievance Associate (GA) will log all grievances in the AmeriHealth Caritas Louisiana Grievances Tracking SharePoint site. The GA will create an acknowledgement letter and mail within five (5) business days of the receipt of the grievance, except in instances where the resolution of the grievance occurs on the same day the grievance is received.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE ensures that the individuals who make decisions on grievances are individuals:</p> <ul style="list-style-type: none"> a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: <ul style="list-style-type: none"> i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. <p style="text-align: right; margin-right: 50px;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 131.201 Member Grievances 2024.docx page 10 • 2024 ACLA QOC Org Chart.docx 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: The Grievance Associate (GA) will initiate the investigation of the grievance and document the actions taken. The GA should also include any additional information that may assist with resolving the grievance. If the grievance requires transferring to</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
another department for assistance in resolving the grievance which includes appropriate clinical review, the GA will refer and follow-up on the status every five (5) business days or sooner until resolution is achieved.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Timely Resolution and Notification of Grievances		
<p>6. The MCE resolves each grievance, and provides notice, as expeditiously as the member’s health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408.</p> <p>MCO and PAHP Standard Grievances</p> <p>a. <i>The MCO/PAHP shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) Calendar Days from the date the MCO/PAHP receives the grievance.</i></p> <p>PIHP Standard Grievances</p> <p>a. <i>For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12)</p> <p>MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 131.201 Member Grievances 2024.docx page 8 • Grievance Resolution Notice.docx • 2024 Grievance Resolution Tracking and Reporting.xlsx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The standard disposition of a grievance and notice to the member is ninety (90) calendar days from the day ACLA receives the grievance. Members will be notified in writing by ACLA of the resolution of grievances. The resolution will include the results of the resolution process and the date it was completed. All notices shall meet the standards described at 42 CFR §438.10.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking and reporting mechanisms Two examples of a grievance with extensions with LDH approval HSAG will use the Universe File to evaluate timeliness HSAG will also use the results of the Grievances File Review 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: If it is determined that the grievance will not be resolved within the 90-day timeframe, ACLA will provide an oral and written notice to the member explaining the reason for the delay. If AmeriHealth Caritas Louisiana extends the timeframe, the Grievance Manager will give the member written notice of the reason for the delay if the extension was not requested by the member.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following:</p> <p style="margin-left: 20px;">a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p style="margin-left: 20px;">b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Grievance extension template letter Two examples of grievances with extensions with oral and written notice HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 131.201 Member Grievances 2024.docx page 10 Audriana G. Pratt Delayed Decision Letter.docx Weaver, James C. 91930998 Grievance Decision_Delayed 11182024.docx Grievance Extensions 2024 Log.docx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: AmeriHealth Caritas Louisiana can also have an additional 14 days if we document that additional time is needed and the delay is in the enrollee’s best interest. If AmeriHealth Caritas Louisiana needs more time, the enrollee is informed orally of the reason for the extension by the end of the day of the decision and in writing within 2 calendar days from the decision date.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Appeals General Requirements		
<p>9. The MCE defines an appeal as a review by the MCE of an ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 4 ACLA Provider Handbook for December 2024.pdf page 219 2024 Member HB English Version_Audit page 54 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: If a member, provider or authorized representative with proper consent, appeals an ABD, the MCE will initiate an appeal following the process attached within the timeframes allowed ensuring review and decision making by a medical director.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The MCE has only one level of appeal for members.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final pages 6-10 ACLA Provider Handbook for December 2024.pdf pages 218-223 2024 Member HB English Version_Audit pages 54, 55 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Member Appeal Medical Director Uphold_Client Letter Redacted.docx ABD Notice.pdf 	
<p>MCE Description of Process: ACLA’s has only one level of internal appeal for members. This is documented in the UM decision letters as well as appeal letters. As the member handbook speaks to only one level of appeal and then directs members to a state fair hearing, no additional levels of internal appeal are implied.</p>		
<p>HSAG Findings: During the compliance review, HSAG identified that LDH’s contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since State requirements differ from federal requirements. HSAG has communicated this information to LDH.</p>		
<p>Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		
<p>11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.</p> <p style="margin-left: 20px;">a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f)</p> <p>MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final pages 6-9 ACLA Provider Handbook for December 2024.pdf pages 220 - 221 2024 Member HB English Version_Audit page 55 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: When a valid expedited appeal is received the case file is packaged with all appropriate medical records and case information and sent to appropriate medical director for review and decision making, oral and written notification of decision is provided before the 72 hour compliance timeframe.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 6 • 2024 Member HB English Version_Audit page 54 • ABD Notice.pdf • ACLA Provider Handbook for December 2024.pdf pages 19 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: If a member, provider or authorized representative with proper consent, appeals an ABD, the MCE will initiate an appeal following the process attached within the timeframes allowed ensuring review and decision making by a medical director. If it is received past the 60-day allowable timeframe the request will be denied for timely filing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>13. The member may file an appeal orally or in writing.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Member consent form template HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 6, 7 2024 Member HB English Version_Audit page 54 Member Written Appeal Request Form.pdf 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The member may file an appeal orally or in writing. A provider on behalf of member, or member representative may file an appeal on behalf of the member with proper written consent.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Handling of Appeals		
<p>14. If the MCE denies a request for expedited resolution of an appeal, it:</p> <p style="padding-left: 20px;">a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).</p> <p style="padding-left: 20px;">b. Follows the requirements in 42 CFR §438.408(c)(2), including:</p> <p style="padding-left: 40px;">i. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p style="padding-left: 40px;">ii. Within two calendar days, gives the member written notice of the reason for the decision to</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Denied expedited resolution letter template HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 7 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f)</p> <p>MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2</p>	<ul style="list-style-type: none"> Member Appeal Expedited_Change to Standard Appeal. 	
<p>MCE Description of Process: If ACLA denies the request for expedited resolution, the appeal will be transferred to the standard timeframe and reasonable effort made to give the member prompt oral notice of the denial of expedited resolution, and followed up within two (2) calendar days of oral notice with a written notice.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. The MCE acknowledges receipt of each appeal.</p> <p>MCO and PAHP:</p> <p>a. <i>The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.</i></p> <p>PIHP:</p> <p>a. <i>Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Appeal acknowledgment template Tracking and reporting mechanisms HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 7 ACLA Member Appeal Acknowledgement Letter_April 2021.docx 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><i>writing is waived in this instance, the grievance must be reported on the grievance log.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1</p>	<ul style="list-style-type: none"> • Appeals ALCA Tracking and Reporting.xlsx 	
<p>MCE Description of Process: AmeriHealth Caritas Louisiana will send the member a letter acknowledging AmeriHealth Caritas Louisiana's receipt of the request for a standard appeal review within five business days of AmeriHealth Caritas Louisiana's receipt of the request from the member, or provider acting on behalf of the member unless the enrollee requests an expedited appeal which will be handled and decided within 72 hours.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>16. The MCE ensures that the individuals who made decisions on appeals are individuals:</p> <p>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</p> <p>b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:</p> <p style="margin-left: 20px;">i. An appeal of a denial that is based on lack of medical necessity.</p> <p style="margin-left: 20px;">ii. An appeal that involves clinical issues.</p> <p>c. Who take into account all comments, documents, records, and other information submitted by the</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Organizational chart of appeal staff members, including credentials • HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 8 • Appeals Decision Org Charts.pptx 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>member or their representative without regard to whether such information was submitted or considered in the initial ABD.</p> <p style="text-align: center;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3</p>		
<p>MCE Description of Process: ACLA ensures that no one involved in the original denial is involved in the decision making of the appeal or any subordinate of such individual. ACLA will ensure that a same or similar match specialty reviews the file of the appeal for decision making.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Six of the 10 appeal case files submitted by ACLA did not provide evidence that the decision-maker was not involved in the previous level of review.</p>		
<p>Required Actions: The MCE must document the names and credentials of decision-makers to ensure the decision-maker has not been involved in the previous level of review.</p>		
<p>17. The MCE treats oral inquiries seeking to appeal an ABD as appeals.</p> <p style="text-align: center;">42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d)</p> <p>MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 6, 7 • 2024 Member HB English Version_Audit page 54 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA will accept oral appeals when received and will route it to the appeals team for appropriate processing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.</p> <p>a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 8 • ABD Notice.pdf • ACLA Member Appeal Acknowledgement Letter_April 2021.docx 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA will allow reasonable timeframes for additional records to be received and uploaded as part of the appeals case file while following compliance timeframes.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD.</p> <p>a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). MCO and PAHP:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>a. <i>Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3</p>	<ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final pages 8, 11 ABD Notice.pdf ACLA Member Appeal Acknowledgement Letter_April 2021.docx 	
<p>MCE Description of Process: ACLA provides notification that the member is entitled to receive upon request and free of charge, reasonable access to and copies of all documents relevant to the appeal.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ACLA’s policy did not include the State requirement to provide the records cited in this requirement within seven calendar days of receipt of the request.</p>		
<p>Required Actions: The MCE must update its policy to include the State requirement to provide the records cited in this requirement within seven calendar days of receipt of the request.</p>		
Resolution and Notification of Appeals		
<p>20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member’s health</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking documentation 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>condition requires, but no later than 30 calendar days from the day the MCE receives the appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1</p>	<ul style="list-style-type: none"> HSAG will use the Universe File to evaluate timeliness HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 9 Appeals ALCA Tracking and Reporting.xlsx 	<input type="checkbox"/> NA
<p>MCE Description of Process: The MCE resolves standard appeals and sends decision letter to the affected parties as expeditiously as the member’s health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal, which includes next level appeal rights.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking and reporting mechanisms HSAG will use the Universe File to evaluate timeliness HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 9 Appeals ALCA Tracking and Reporting.xlsx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA resolves expedited appeals and sends decision letter to the affected parties no later than 72 hours after ACLA receives the appeal, which includes next level appeal rights.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final pages 9, 10 • Appeals ALCA Tracking and Reporting.xlsx 		
MCE Description of Process: Extensions apply to standard appeals only. If a member requests an extension on an expedited appeal, we will downgrade to standard and work as expeditiously as possible. There were no extensions for 2024, all were decided within the standard timeframes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Two examples of appeals with extended time frame with oral and written notice 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p>b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision.</p> <p>c. Resolves the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2</p>	<ul style="list-style-type: none"> Appeal extension template letter HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 10 ACLA Member Appeal Extension Letter.docx 	
<p>MCE Description of Process: Extensions apply to standard appeals only. If a member requests an extension on an expedited appeal, we will downgrade to standard and work as expeditiously as possible. There were no extensions for 2024, all were decided within the standard timeframes.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE’s appeals process. The member may initiate a State fair hearing (SFH).</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 10 • 2024 Member HB English Version_Audit page 56 • Appeals ALCA Tracking and Reporting.xlsx 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: State Fair Hearing expectations are provided to the member via the member handbook. ACLA does not have an appeal notice letter template for untimely appeal resolution but would be able to draft one should there be a case where the appeal was not resolved timely.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>25. For all appeals, the MCE provides written notice of the appeal resolution that includes:</p> <p style="padding-left: 20px;">a. The results of the resolution process and the date it was completed.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>b. For appeals not resolved wholly in favor of the member:</p> <ul style="list-style-type: none"> i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal. <p>MCO:</p> <ul style="list-style-type: none"> a. <i>The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.</i> b. <i>The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.</i> c. <i>For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the enrollee of their right to seek a State Fair Hearing if the enrollee is not satisfied with the MCO's decision in response to an appeal, and the process for doing so.</i> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.</i> b. <i>The PAHP shall include on the notice a unique identifying number, corresponding to the number on</i> 	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 10 • Member Appeal Medical Director Overturn_Client Letter.docx • Member Appeal Medical Director Uphold_Client Letter Redacted.docx <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Grievance and Appeal Systems 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><i>the notice of adverse benefit determination that gave rise to the appeal.</i></p> <p>c. <i>The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP’s decision in response to an appeal, and the process for doing so.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4)</p> <p>MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13</p>		
<p>MCE Description of Process: All appeal decisions are sent to the appropriate parties in writing and includes next level appeal rights, the right to request a SFH, and how to do so. The decision includes the right to request and receive benefits while the hearing is pending, and how to make the request, as well as verbiage indicating that the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the ACLA's ABD related to the appeal.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. ALCA was unable to provide evidence of approval from LDH for the appeal resolution template.</p>		
<p>Required Actions: The MCE must submit the appeal resolution template to LDH for approval.</p>		
<p>26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice.</p> <p>MCO and PAHP:</p> <p>a. <i>In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 9 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2		
MCE Description of Process: In relation to an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice and documents the oral attempt in the case file as well as sending a written decision letter all within the 72 hour timeframe which is stricter than the additional two calendar days for written decisions per NCQA.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Fair Hearings and State External Review		
27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal. <ol style="list-style-type: none"> a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member. 	HSAG Required Evidence: <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03 MCO Contract: 2.15.1.11; 2.15.4.1 PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final pages 7, 10 • Member Appeal Medical Director • Uphold_Client Letter Redacted.docx • ABD Notice.pdf • 2024 Member HB English Version_Audit page 56 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The member may request a State Fair Hearing once the internal level of appeal is completed. In the decision letter provided, the State Fair Hearing rights and instructions are provided.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Six of the nine appeal case files that ACLA submitted required written member consent; however, the case files did not include the member’s written consent.</p>		
<p>Required Actions: The MCE must ensure written consent is obtained when the member requests a State fair hearing (SFH) after receiving notice that the MCE is upholding the ABD related to the appeal.</p>		
<p>28. The member has <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p> <p>MCO:</p> <p>a. <i>An enrollee or other party to the appeal, who has completed the MCO’s appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p>PAHP:</p> <p>a. <i>An enrollee or authorized representative, who has completed the PAHP’s appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 10 • Member Appeal Medical Director Uphold_Client Letter Redacted.docx • ABD Notice.pdf • 2024 Member HB English Version_Audit page 56 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <p>a. <i>The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP’s notice of resolution.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2</p>		
<p>MCE Description of Process: The member has 120 calendar days from the date of ACLA’s notice of appeal resolution to request an SFH. These instructions are provided for all appeals in the decision letter.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Continuation of Benefits		
<p>29. The MCE continues the member’s benefits if all of the following occur:</p> <p>a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).</p> <p>b. The appeal involves the termination, suspension, or reduction of previously authorized services.</p> <p>c. The services were ordered by an authorized provider.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 11 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>d. The period covered by the original authorization has not expired.</p> <p>e. The member timely files for continuation of benefits.</p> <p>MCO/PAHP/PIHP:</p> <p>a. <i>Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.</i></p> <p><i>Timely files</i> means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE’s proposed ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(a-b)</p> <p>MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2</p>	<ul style="list-style-type: none"> Member Appeal Medical Director Overturn_Client Letter.docx Member Appeal Medical Director Uphold_Client Letter Redacted.docx ABD Notice.pdf 	
<p>MCE Description of Process: ACLA will continue Member benefits if:</p> <ol style="list-style-type: none"> 1. The member, authorized representative or the provider, acting on behalf of the member and with the member’s written consent can file the appeal timely in accordance with 42 CFR 438.402 c(1)(ii) and c(2)(ii); 2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; 3. The services were ordered by an authorized provider; 4. The original period covered by the original authorization has not expired; 5. The member requests an extension of benefits. 		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>30. If, at the member’s request, the MCE continues or reinstates the member’s benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs:</p> <p>a. The member withdraws the appeal or request for SFH.</p> <p>b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member’s appeal.</p> <p>c. A SFH office issues a hearing decision adverse to the member.</p> <p>MCO and PAHP:</p> <p>a. Appeals</p> <p style="padding-left: 20px;">i. <i>The time period or service limits of a previously authorized service has been met.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(c)</p> <p>MCO Contract: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 11 • ABD Notice.pdf 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA will continue or reinstate the member’s benefits, at the member’s request, while:</p> <p>The appeal is pending until one of the following occurs:</p> <ol style="list-style-type: none"> 1. The end of the treatment period. 2. The member withdraws the appeal or State Fair Hearing. 3. Ten (10) calendar days pass after ACLA mails the appeal determination notification and the member, within the ten (10) day timeframe, has not requested a State Fair Hearing. 4. A State Fair Hearing Officer issues a hearing decision adverse to the member. 5. The time period or service limits of previously authorized service has been met. 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE’s ABD, the MCE may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE’s contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(d)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures GAP • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 11 • ABD Notice.pdf • Member Appeal Medical Director Uphold_Client Letter Redacted.docx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: In the appeal decision notification, the member is notified that they may have to pay the costs of this service if they continue to receive it. This could happen if the fair hearing decision is to deny services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(b)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2</p>	<p>HSAG Required Evidence: Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 12 • SFH SOP.docx 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: In the decision notification, ACLA must overturn and effectuate the decision. ACLA submits documentation of the overturned decision to LDH and the Administrative Law Judge, as well as tracks on the applicable regulatory report submitted to LDH.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Reinstatement of Services		
<p>33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i)</p> <p>MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1</p>	<p>HSAG Required Evidence: Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 12 • Appeals ALCA Tracking and Reporting.xlsx 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: If an appeal is overturned by ACLA or the State Fair Hearing officer, a reversal/effectuation is completed as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Effectuation is documented in the case file.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievances, Appeals, and State Fair Hearings		
<p>34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Example of assistance to members on filing a grievance <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ACLA 131.309 Appeal Policy 2024 Final page 5 131.201 Member Grievances 2024.docx page 10 2024 Member HB English Version_Audit pages 9, 56 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA gives members any reasonable assistance filing a grievance and appeal or asking for a state fair hearing by contacting Member Services. Our Member Services representative may accept the grievance orally or assist member in completing the form. The Member Services representative will submit the request to the appropriate department for resolution. This information is included in the letters for the members awareness.</p> <p>As part of the appeal process in Policy 131-309, members are provided assistance when requested in related to all outline in Element 34.</p> <p>Note: Example of assistance to members on filing a grievance – There were no requests for assistance during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10.</p> <p style="text-align: right;">42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 5.15.2; 5.15.3</p>	<p>HSAG Required Evidence: Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 131.201 Member Grievances 2024.docx pages 5, 7 • ACLA 131.309 Appeal Policy 2024 Final page 10 • Member Appeal Medical Director Overturn_Client Letter.docx • Member Appeal Medical Director Uphold_Client Letter Redacted.docx • Grievance Resolution Notice Template.docx • Reading Level Mechanisms.docx <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Mechanism to Assess Reading Level of Member Appeal Notices 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA provides written notice of the appeal and grievance resolution in a format and language that, at a minimum, meets the requirements in federal regulations. There is a readability score and standard operating procedure to ensure this requirement is met.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The resolution letters for all of the 10 grievance case files and one of the 10 appeal case files were not compliant with the state-required reading grade level.</p>		
<p>Required Actions: The MCE must ensure that all grievance and appeal resolution letters meet the state-required reading grade level.</p>		
<p>36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.</p> <p style="text-align: right;">42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g)</p> <p>MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1</p>	<p>HSAG Required Evidence: Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 159.302 Provider Contract page 6 • Delegated Agreement Services Template.docx page 5 • 131.201 Member Grievances 2024.docx page 9 • ACLA Provider Handbook for December 2024.pdf pages 218-223 • ACLA Ancillary-Svrs-Agmt (08-01-2022).docx pages 3, 6 • ACLA Hospital_Svrs_Agmt (08-091-2022).docx Pages 3, 7 • ACLA PCP_Svrs_Agmt Template (08-01-2022).docx pages 3, 6 • ACLA Specialist_Svrs_Agmt (08-01-2022).docx pages 3, 7 • LA Required Subcontractor Provisions 1.1.2023 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: PNM will provide orientation to providers 30 days after they enter a contract with ACLA and is fully credentialed with the plan. During the orientation PNM will give an overview of member information, key departments, provider information, provider resources, payment processes, 1st and 2nd level disputes and appeals.</p> <p>Subcontractors are subject to all ACLA requirements via the LA Required Subcontractor Provisions and subcontractor statements of work, including specificity about providing assistance to ACLA when members submit a grievance about their performance or the quality of services rendered. These grievances are tracked internally and reported to LDH via required regulatory reporting.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>37. The MCE includes as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. <p style="text-align: right; margin-right: 50px;"> 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) </p> <p>MCO Contract: 2.15.3.1.6 PAHP Contract: 2.10.3.1.5 PIHP Contract: 11.4.2.4.2; 11.4.14.5</p>	<p>HSAG Required Evidence: Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook and/or notice templates <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA 131.309 Appeal Policy 2024 Final page 8 • 2024 Member HB English Version_Audit page 54 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Members may contact AmeriHealth Caritas Louisiana if there are questions or concerns related to the NABD and their feedback is documented in the system and subsequently reviewed by the Appeals Team. Doctors and/or other authorized to act on the member’s behalf are also allowed to provide information deemed applicable to the decision to be used during the appeal review.</p> <p>There are no limitations on participation in the State Fair Hearing and ACLA’s representation includes the Compliance Department and medical professionals as appropriate.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Recordkeeping Requirements		
<p>38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information:</p> <ol style="list-style-type: none"> a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. <p>PIHP:</p> <ol style="list-style-type: none"> a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members; f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals; h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and 	<p>HSAG Required Evidence: - Evidence Complete</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 131.201 Member Grievances 2024.docx page 11 • ACLA 131.309 Appeal Policy 2024 Final page 3 • Grievance Tracking and Reporting log 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health 2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>i. The number of State Fair Hearings and resolution during the reporting period.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h)</p> <p>MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2</p>		
<p>MCE Description of Process: For Grievances: ACLA provides an electronic report of plan grievances to LDH monthly via the 010 and 409 Grievance, Appeal, and State Fair Hearing Logs. The report will include member’s name and Medicaid number, summary of grievances, date of filing, status, date of review or review meeting, resolution information for each level of grievance; date of resolution at each level and resulting corrective action.</p> <p>For Appeals: ACLA will maintain accurate records of all appeals in a manner accessible to LDH and available upon request to CMS. A copy of records of resolution of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, which is later.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	32	X	1	=	32
	Not Met	=	5	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	Total Score	=	32	

Total Score ÷ Total Applicable	=	86%
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Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Certification		
<p>1. Documentation or information the MCE submits to LDH is certified by the MCE’s Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.</p> <p>a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful.</p> <p>b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o)</p> <p>MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures to certify the data specified in 42 CFR §438.604 Position and job description of individual responsible for certification <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A <p>Additional Documentation:</p> <ul style="list-style-type: none"> 178.011 - Encounters Attestation Policy CEO Job Description CFO Job Description COO Job Description 145 ACLA 2024 Q4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: All of ACLA’s reports include attestations by the Market President, Chief Financial Officer, or a direct report.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Compliance Program/Program Integrity Plan		
<p>2. The MCE develops a compliance program that includes:</p> <p>a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.</p> <p>b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.</p> <p>c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under the Contract.</p> <p>d. A system for training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees, for the Federal and State standards and requirements under the Contract.</p> <p>MCO and PAHP:</p> <p>a. <i>Fraud, waste, and abuse training shall include, but not be limited to:</i></p> <p style="padding-left: 20px;">i. <i>Annual training of all employees; and</i></p> <p style="padding-left: 20px;">ii. <i>New hire training within thirty (30) Calendar Days of beginning date of employment.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Compliance Program Description <ul style="list-style-type: none"> – 2a – page 6 – 2b – page 7 – 2c – pages 4-5 – 2d – pages 8-11 • Dir Compliance_B45019 • AHC code-of-conduct 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>b. <i>The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:</i></p> <ul style="list-style-type: none"> i. <i>MCO/PAHP Code of Conduct Training;</i> ii. <i>Privacy and Security - Health Insurance Portability and Accountability Act;</i> iii. <i>Fraud, Waste, and Abuse identification and reporting procedures;</i> iv. <i>The False Claims Act and employee whistleblower protections;</i> v. <i>Procedures for Timely consistent exchange of information and collaboration with LDH;</i> vi. <i>Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and</i> vii. <i>Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.</i> <p>c. <i>Effective lines of communication between the compliance officer and the organization's employees.</i></p>	<ul style="list-style-type: none"> Progressive Discipline Policy 2024 ACLA Program Integrity Plan Associate Guidebook Compliance Committee Charter Program Integrity Org Chart Compliance Training- NHO 08.2023 NHO Tracker 2024 Fraud, Waste, and Abuse 2024-2025 HIPAA 2024-2025 (eLearning) Compliance Our Culture & the Law 2024-2025 All PP_LDH Requirements 2024 ACLA Compliance Work Plan 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>d. <i>Enforcement of standards through well-publicized disciplinary guidelines.</i></p> <p>e. <i>Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.</i></p> <p>PIHP:</p> <p>a. <i>Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;</i></p> <p>b. <i>A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;</i></p> <p>c. <i>Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if</i></p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;</i></p> <p>d. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and</i></p> <p>e. <i>Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(1)</p> <p>MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7</p> <p>PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9</p> <p>PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11</p>		
<p>MCE Description of Process: AmeriHealth Caritas’ Compliance Program is achieved through coordination between AmeriHealth Caritas Compliance Shared Services and AmeriHealth Caritas Louisiana (ACLA). ACLA’s Compliance Officer, who also serves as the Program Integrity Officer, develops the ACLA Compliance Plan. The ACLA Compliance Director works in consort with the Corporate Shared Services team on policies and procedures designed to meet federal and state regulatory requirements. ACLA’s Compliance Department reports to the ACLA COO for contractual compliance concerns and to the Shared Services department for policy and procedure compliance. We have a Compliance Committee that meets at least three times a year and is responsible for reviewing and approving the annual Compliance Plan. The approved Compliance Plan is presented to the Board of Directors for review and approval, at least annually, prior to submitting to LDH for review and approval. Training is conducted for all new staff as part of the onboarding process and is completed within 30 days of hiring. Ongoing and annual training of all staff related to applicable Federal and State laws, regulations, rules and policies is done via online training.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>The Hotline number for reporting any concerns is widely publicized on the Company’s intranet and regularly reinforced and held to the disciplinary guidelines for any confirmed non-compliance with Company policy. There are audit teams at the corporate level, and ACLA’s Compliance department conducts focused audits.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP: a. <i>The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.</i></p> <p>MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Compliance Program Description, page 7 • 669-117 Corrective Action Plans 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Corrective Action Plans define the process by which corrective actions are to be implemented, and the timelines associated with remediation efforts. This policy is followed for non-compliance identified internally or externally.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. Additional compliance program requirements: MCO: a. <i>The MCO’s compliance program shall incorporate the following requirements:</i> i. <i>Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching, trending, statistical analysis, monitoring service</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 106.100.003 Fraud and Abuse Detection updated, Page 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>and billing patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>ii. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.</i></p> <p>iii. <i>Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.</i></p> <p>iv. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.</i></p> <p>PAHP:</p> <p>a. <i>Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.</i></p>	<ul style="list-style-type: none"> • Policy 106.100.003 Attachment A Fraud and Abuse Detection, page 1 • Policy 106.100.005 Referrals to External Agencies Updated Pages 1&2 • Policy 106.100.005 Attachment A External Agencies, Pages 1&2 • Policy 106.100.008 Fraud and Abuse Investigations updated, Page 1 • Policy 106.100.008 Attachment A Fraud and Abuse Investigations Page 1 • Policy 106.100.012 State Agency Reports updated, Page 1 • Policy 106.100.012 Attachment A State Agency Reports, Page 1 • Policy 106.100.016 Investigative Site Visits, Page 1 • Policy 106.100.016 Attachment A Investigative Site Visits, Page 1 • 669.103 Compliance Tools for Effective Lines of Communication_2024 • 2024 ACLA Compliance Program Description <ul style="list-style-type: none"> – 4.a.iii - page 7 and 10-11 • 2024 ACLA Program Integrity Plan <ul style="list-style-type: none"> – 4.a.i - pages 1, 2, 5, 6 – 4.a.ii - pages 5-8 • 106.100.007 Associate Reporting of Fraud Waste or Abuse 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> b. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.</i> c. <i>Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.</i> d. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.</i> e. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP’s website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The PIHP’s fraud, waste and abuse policies and procedures shall provide and certify that the PIHP’s fraud, waste and abuse unit has access to records of providers.</i> <ul style="list-style-type: none"> i. <i>The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP’s senior management.</i> b. <i>Description of effective training and education for the compliance officer, the organization’s employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it</i> c. <i>A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.</i> <p>MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12</p>		
<p>MCE Description of Process: The AmeriHealth Caritas Compliance Department maintains company oversight of ACLA’s compliance standards and provides direct oversight of ACLA’s SIU team. The toll free compliance number is maintained at the Corporate level, and staff conduct thorough reviews of all reported concerns. The Compliance Department conducts regular due diligence of identified trends in order to identify and implement measures designed to proactively prevent FWA.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>5. Publicized email address: MCO and PAHP:</p> <p>a. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.</i></p> <p>b. <i>The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i></p> <p>MCO:</p> <p>a. <i>The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.</i></p> <p>MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 ACLA Program Integrity Plan <ul style="list-style-type: none"> – 5.a, page 1 – 5.b, page 2 • 2024 Compliance Program Description <ul style="list-style-type: none"> – 5.a, page 11 – 5.b, page 11 • ACLA Site and FWA Page Memo, Page 1 • Policy 106.100.012 State Agency Reports updated, page 1 • RE 2024 FWA Compliance Plans Due by January 30 • 669-103 Compliance Tools for Effective Lines of Communication_2024 • 106.100.007 Associate Reporting of Fraud Waste or Abuse, p 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • The email address fraudtip@amerihealthcaritas.com is on page 191 of the ACLA Provider Handbook 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The AmeriHealth Caritas Compliance Department maintains company oversight of ACLA’s compliance standards and provides direct oversight of ACLA’s SIU team. The toll-free compliance number and dedicated Fraud tip email is maintained at the Corporate level, and staff conduct thorough reviews of all reported concerns.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that the MCE simplify the secure contact form on its website to ease use for members, providers, and other users. Perhaps the form could filter for members or providers, or the MCE can determine additional functionality that would make fraud reporting (and other uses) more user-friendly.</p>		
<p>Required Actions: No action required.</p>		
Overpayments and Treatment of Recoveries		
<p>6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH.</p> <p style="text-align: right;">42 CFR §438.608(a)(2)</p> <p>MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures, including timeline for prompt reporting of overpayments Special investigations unit (SIU) workflows Identification mechanisms Reporting mechanisms Provider materials, such as the provider manual and provider contract Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 106.100.012 State Agency Reports updated, p 1 Policy 106.100.012 Attachment A State Agency Reports, p 1 ACLA Provider Handbook for December 2024-FINAL page 152 of PDF, Standard XIV Program Integrity Audit Element 6 Pages 167 – 169 of PDF 8 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Any MCO overpayments identified by the Special Investigations Unit (SIU) are documented in the financials in STARS Commander, the case management database, to be tracked until the recovery is complete. The SIU communicates the notice for overpayment recoveries to the Credit Balance Unit (CBU). The CBU operates as a Collections team for the Enterprise. The treatment of recoveries is primarily managed by the CBU, and the CBU provides monthly updates to the SIU for updates to the financial portion of the case. The treatment of recoveries includes review of provider spend to determine if dollars should be transferred to other payee IDs as well as transferring outstanding balances, at the payee level, to GB Collects. The status of all recoveries is reported on FWA regulatory reports on a monthly and quarterly basis to LDH.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.</p> <p>a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments.</p> <p>b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials • Most recent report of recoveries of overpayments to State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 106.100.012 State Agency Reports updated, page 1 • Policy 106.100.012 Attachment A State Agency Reports, page 1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.</p> <p>MCO:</p> <p>a. <i>Report annually to LDH, in a form and format specified by LDH, on the MCO’s recoveries of overpayments in accordance with 42 CFR §438.608.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.</i></p> <p>b. <i>The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.</i></p> <p>PIHP:</p> <p>a. <i>The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.</i></p> <p>b. <i>The PIHP shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.</i></p>	<ul style="list-style-type: none"> Policy 106.100.020 Attachment A Provider Dispute, Page 1 Policy 106.100.020 SIU Provider Overpayment Dispute, Page 1 ACLA Provider Handbook for December 2024-FINAL, p 145 145 ACLA 2024 Q3 Evidence of the annual recoveries of overpayments report submission to LDH. <p>Additional Documentation:</p> <ul style="list-style-type: none"> 145 ACLA 2024 Q4 145 ACLA 2024 Q4 LDH Approval 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3)</p> <p>MCO Contract: 2.20.2.2.15; 2.20.7.3 PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6</p>		
<p>MCE Description of Process: Any MCO identified overpayment during an audit is reported by the Special Investigations Unit (SIU). The SIU will provide notice to and/or obtain approval from any applicable State or Federal agency before pursuing the recovery of the overpayments from providers for findings for FWA. Identified overpayments are reported when after the initial coding review of the records and the dispute period expiration date. All overpayments are reported on monthly and quarterly FWA regulatory reports and submitted to LDH.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment.</p> <p style="text-align: right;">42 CFR §438.608(d)(2)</p> <p>MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • ACLA Provider Handbook for December 2024-FINAL page 152 of PDF, Pages 167–169 of PDF • Physical Health Provider Orientation, Slide 58 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Claims Filing Instructions 2024, p 8 • 106.100.018 Provider Self Audit 	
<p>MCE Description of Process: Any overpayments identified by the provider can be returned to the health plan by submitting the refund check with the enrollee's name and ID, date of service, and claim ID by mail to the Claims Processing Department. If a provider prefers that the improper payment or overpayment be recouped from future claim payments, the overpayment must be reported by calling Provider Services, or a request can be sent in writing for recoupment.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notification of Member and Provider Changes		
<p>9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member’s circumstances that may affect the member’s eligibility including all of the following:</p> <p style="margin-left: 20px;">a. Changes in the member’s residence;</p> <p style="margin-left: 20px;">b. The death of a member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(a)(3)</p> <p>MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 532-015 - Disenrollment and Enrollment Process, PAGE 2-3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
PIHP Contract: 14.8.1.4		
<p>MCE Description of Process: Any MCO initiated requests for disenrollment are routed to ACLA Compliance Director for review and submission to LDH. The Compliance Director validates that the request meets one of the allowed circumstances to request disenrollment and upon confirmation, submits request to LDH for review. ACLA continues to provide all covered services to the member until such time that LDH has disenrolled the member and notified ACLA via 834 file. While there are no official training materials, these topics are discussed during departmental staff meetings and in management meetings, as a reminder that LDH will only be informed of a change in member’s residence if the MCO proactively submits that change to LDH.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider’s circumstances that may affect the network provider’s eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 159.301 Provider Termination page 8 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Termination for Cause 9.12.24 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, 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. The notification shall include:</i></p> <ul style="list-style-type: none"> <i>i. Information about how the provider network change will affect the delivery of covered services; and</i> <i>ii. The PAHP’s plan for maintaining the quality of enrollee care if the provider network change is likely to affect the delivery of covered services.</i> <p>PIHP:</p> <ul style="list-style-type: none"> <i>a. The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, 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:</i> <ul style="list-style-type: none"> <i>i. Information about how the provider network change will affect the delivery of covered services, and</i> <i>ii. The PIHP’s plan for maintaining the quality of member care if the provider network change is likely to affect the delivery of covered services.</i> <p style="text-align: right;"><i>42 CFR §438.608(a)(4)</i></p> <p>MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
PIHP Contract: 6.6.5		
<p>MCE Description of Process: When ACLA receives information about a change in a network provider’s circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE, notification is sent to ACLA’s Compliance Director. The Compliance Director subsequently submits notice to LDH Program Integrity and LDH Managed Care departments, notifying of the termination. These requirements, while not included in any official staff training, are reinforced through departmental staff meetings and management meetings.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Verification of Services Provided		
<p>11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.</p> <p>MCO:</p> <p>a. <i>On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e).</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 147 ACLA 2024 Q4 • MSV SIU PROCESS • 106.100.013 Member Service Verification 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>In easily understood language, the required notice shall specify:</i></p> <ul style="list-style-type: none"> i. <i>Description of the service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished;</i> iv. <i>The amount of the payment made for the service; and</i> v. <i>The method for notifying the Contractor of services not rendered.</i> <p>b. <i>The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis.</i></p> <p>c. <i>The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).</i></p> <p>d. <i>The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i></p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> • 11(a) EOB Template (SIU) • 11(b) & 11(3) Program Integrity Policy 655.100.013 and Attachment A (SIU) 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>e. <i>Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the MCO’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.</i></p> <p>PAHP:</p> <p>a. <i>On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:</i></p> <ul style="list-style-type: none"> i. <i>Description of the service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished; and</i> iv. <i>The amount of the payment made for the service.</i> <p>b. <i>Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The</i></p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis.</i></p> <p>c. <i>The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and</i></p> <p>d. <i>Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.</i></p> <p>e. <i>Within three (3) business days, results indicating that paid services may not have been received shall be referred to the PAHP’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.</i></p> <p>PIHP:</p> <p>a. <i>On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:</i></p> <ul style="list-style-type: none"> i. <i>The service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> iii. <i>The date on which the service was furnished; and</i> iv. <i>The amount of the payment made for the service.</i> b. <i>The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.</i> c. <i>Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.</i> d. <i>The Contractor shall over sample particular provider groups upon request by LDH.</i> e. <i>The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i> f. <i>Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor’s fraud and abuse department for review and to LDH’s designated Program Integrity contact.</i> g. <i>The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were</i> 		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH.</i></p> <p style="text-align: center;">42 CFR §438.608(a)(5)</p> <p>MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4</p>		
<p>MCE Description of Process: AmeriHealth Caritas conducts data aggregation across all claim types on a quarterly basis and identifies a random representative sample to send EOBs to members to identify any potential instances of fraudulent billing. Responses are captured if submitted by mail or phone and any potential FWA is routed to the SIU for investigation. Quarterly review samples are submitted to LDH. AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Whistleblower Protection		
<p>12. In the case of MCEs that make or receive annual payments under the contract of at least \$5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Associate Guidebook, Whistleblower pgs. 11-15 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>information about rights of employees to be protected as whistleblowers.</p> <p>MCO:</p> <p>a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO’s policies and procedures for detecting and preventing fraud, waste and abuse.</p> <p style="text-align: right;">42 CFR §438.608(a)(6)</p> <p>MCO Contract: 6.18.1; 6.18.3 PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7 PIHP Contract: 13.1.1.2.; 13.1.2.8</p>	<ul style="list-style-type: none"> 2024 ACLA Compliance Program Description, pgs. 8, 9, 21, 23 Compliance Our Culture & the Law 2024-2025, p 18-26 of PDF 669-118 Federal and State False Claims Act Provisions Penalties and Protections_2024 FINAL 106.100.007 Associate Reporting of Fraud Waste or Abuse, p 1 	
<p>MCE Description of Process: Information related to compliance with 42 CFR §438.608(a)(6) is included in the ACLA Compliance Program Description, compliance P&Ps, and executed subcontractor agreements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Fraud, Waste, and Abuse		
<p>13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures:</p> <p>a. That are designed to detect and prevent fraud, waste, and abuse.</p> <p>b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH’s program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU).</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Fraud, waste, and abuse plan SIU workflow Reporting mechanisms Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PRX CORE 1-01 pg 2. Section 1.A 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>PAHP:</p> <p>a. <i>The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process should be developed to expedite information for appropriate disposition.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(a) 42 CFR §438.608(a)(7)</p> <p>MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4</p>	<ul style="list-style-type: none"> • PRX CORE 1-01 pg. 9 Section 15 B. & C • PRIME 8038 <ul style="list-style-type: none"> – a) Pg 2 IV Policy Standards – b)PRIME Compliance Program Description pgs 33- 34 • PRIME Compliance Policy pg. 14 • PRIME_SIUPA_PHARMSIU_09LAMCD • Pharmacy Investigations SOP pg 2 #2 b.i • PRIME Compliance Program pg 34 • PIHP – PRIME Compliance Program Description pgs 33- 34 • PRIME Compliance Policy pg. 14 • Evolent COM.013.E pg. 2 “Purpose” • Evolent COM.013.E pg 5. Section II.D • Policy 106.100.003 Fraud and Abuse Detection updated, Page 1 • Policy 106.100.003 Attachment A Fraud and Abuse Detection, page 1 • Policy 106.100.005 Referrals to External Agencies Updated Pages 1&2 • Policy 106.100.005 Attachment A External Agencies, Pages 1&2 • Policy 106.100.008 Fraud and Abuse Investigations updated, Page 1 • Policy 106.100.008 Attachment A Fraud and Abuse Investigations Page 1 	



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Policy 106.100.012 State Agency Reports updated, Page 1 Policy 106.100.012 Attachment A State Agency Reports, Page 1 Fraud, Waste, and Abuse 2024-2025 	
<p>MCE Description of Process: Any MCO identified fraud findings from the Special Investigations Unit (SIU) are reported to the Louisiana Department of Health (LDH) on an MCE Suspected Provider Fraud Referral Form. The SIU workflow reporting process starts with the SIU Investigator identification of fraud. The investigator promptly reports the fraud findings to the SIU Manager for a review. After discussion with the Manager, the investigator completes a fraud referral form with supporting documentation that includes claims data that is used to create a fraud referral package. The SIU Manager approves the fraud referral package and sends it via secure email to LDH and MFCU. The ACLA Compliance Director is included on the secure email to LDH and MFCU for awareness. After the fraud referral is submitted, the case is placed in stand down status with the disposition for a referral to law enforcement/regulatory. The case remains in stand down status until the LDH sends the SIU approval to proceed with the investigation. The identification of fraud findings is reported to LDH on the quarterly FWA report.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Suspension of Payments		
<p>14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Payment suspension workflow Staff training materials 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>there is a credible allegation of fraud in accordance with 42 CFR §455.23.</p> <p style="text-align: right;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PRIME_SIUPA_PHARMSIU_09LAMCD Pharmacy Investigations SOP pg 3 b.i Policy 106.100.015 Provider Payment Suspension.pdf Policy 106.100.015 Attachment A Provider Payment Suspension.pdf 159.301 Provider Termination Policy page 5 	
<p>MCE Description of Process: ACLA’s Director of Compliance maintains all records related to payment suspension and reinstatement of payment. Additionally, the Director of Provider Network Operations ensures that all LDH required information is entered into LDH’s SharePoint site.</p> <p>The Special Investigations Unit (SIU) monitors any state-initiated provider payment suspension to ensure, at an enterprise-level, compliance with State and/or Federal requirements. Additionally, should a provider not submit the requested medical records for, and SIU post pay review - a payment suspension request is submitted to the ACLA Compliance Director for review/approval. Upon approval, the SIU sends the provider notice of the payment suspension that gives the provider 15 days to comply before Provider Network Operations (PNO) applies the suspension. A SIU initiated payment suspension can extend for 60 days if the requested records are not received</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c).</p> <p style="text-align: right;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Payment suspension workflow, including applicable timeframes • Notice of payment suspension letter template • Staff training materials • HSAG will also use findings from the provider payment suspensions tracking system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • PRIME_SIUPA_PHARMSIU_09LAMCD • Pharmacy Investigations SOP pg 3 b.i • Policy 106.100.015 Provider Payment Suspension, P 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Payment Suspension Letter MRR Template 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: ACLA’s Director of Provider Network Operations, or designee will generate the payment suspension notification letter to the Provider with required elements as defined by 42 C.F.R. § 455.23 and will mail the Provider Notification Letter to the applicable provider via certified mail.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
Provider Screening and Enrollment Requirements		
<p>16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E.</p> <p style="text-align: right;">42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E</p> <p>MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 159.302 Provider Contracts, p 5 • Medicaid Enrollment Verification_1 • Medicaid Enrollment Verification_2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: ACLA’s Provider Network Management Department works with providers to ensure they are registered with LDH through the Medicaid portal (if invitation letter has been received), complete a provider contract and required documentation for provider credentialing. All documents must be received and completed before they are sent to credentialing, and the contract is executed.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures 	<input checked="" type="checkbox"/> Met



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days.</p> <p style="margin-left: 20px;">a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.602(b)(2)</p> <p>MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5</p>	<ul style="list-style-type: none"> Medicaid enrollment timeliness tracking mechanisms Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 159.302 Provider Contracts, p 5 	<input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Once Provider Network Management has been notified by LDH of a network provider termination, we request termination of credentialing and terminate them in our payment system. A letter will be sent notifying the provider of the termination. We will run a report on all members seen by that provider within the past 12 months, send the members a letter, and assist in finding another provider. The identification and tracking of Medicaid enrollment occurs through automated electronic submissions.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Disclosures and Prohibited Affiliations		
<p>18. The MCE, and any subcontractors:</p> <p style="margin-left: 20px;">a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures that apply to provider/contracted entities and the MCE 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.</p> <p>c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract.</p> <p>MCO:</p> <p>a. <i>Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars (\$25,000), even if there is no suspicion of fraudulent activity.</i></p> <p style="text-align: right;">42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610</p> <p>MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13</p>	<ul style="list-style-type: none"> Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) Disclosure of ownership and control notice template (required for completion by contracted entities) Confirmation MCE disclosures were provided to LDH upon contract execution Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PRX CORE 1-03 Financial Incentives for Utilization Review PRX CORE 1-18 Oversight of Downstream Entities pg. 2 .C AHC Code of Conduct pg. 4 Section C PRIME 8015 Government Programs Exclusions and Debarment Policy pg 2 Evolent COM.013.E pg. 5 Section II Evolent COM.013.E pg. 6 Section III Evolent COM.024.E pg 5 2024 ACLA Compliance Program Description 552-003 Provider Exclusion Monitoring 2024 	<input type="checkbox"/> NA
<p>MCE Description of Process: ACLA complies with LDH requirements related to required ownership disclosure via annual Disclosure of Ownership submission and inclusion of corresponding disclosures with all subcontractor agreements.</p> <p>AmeriHealth Caritas provides standardized training to all new associates within their first 30 days of hire and annually thereafter, inclusive of interactive FWA trainings that are consistently reviewed and updated as rules and regulations are updated. Corporate Compliance</p>		



Louisiana Department of Health
2025 Compliance Review for AmeriHealth Caritas Louisiana

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
communicates via a company wide distribution list relevant updates to the entire company. ACLA is required to submit proof of all LDH required trainings annually and is compliant with LDH’s contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	18	X	1	=	18
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	Total Score		=	18

Total Score ÷ Total Applicable	=	100%
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Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	Evidence as Submitted by the MCE		Score
1. <div style="text-align: right; margin-right: 100px;"><Insert federal CFR citation></div> Contract: <Insert Citation(s)>	MCE Document Submission: <ul style="list-style-type: none"> • 		<input type="checkbox"/> Met <input type="checkbox"/> Not Met
HSAG Findings:			
Required Actions:			
Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
CAP Approval Status:			
Submission:			