Amerihealth Caritas Louisiana

2016 Compliance Audit

Review Period: September 2015 – August 2016

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

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Section 1: Introduction and Audit Overview

INTRODUCTION

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

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

This report presents IPRO's findings of the 2016 Annual Compliance Audit for Amerihealth Caritas Louisiana (Amerihealth).

AUDIT OVERVIEW

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

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

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

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

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

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

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

Table 1: File Review Sample Sizes

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

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

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

Table 2: Review Determination Definitions

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

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

Pre-onsite Documentation Review

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

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

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

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

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

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

Onsite Visit

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

The IPRO audit team visited Amerihealth in December 5–6, 2016 to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and for the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy was conducted in accordance to state standards.

Post-onsite Report Preparation

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

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

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

Section 2: MCO Summary of Findings

SUMMARY OF FINDINGS

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

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	N/A	% Full
Core Benefits and Services	123	112	10	1	0	0	91%
Provider Network	163	149	9	3	0	2	93%
Utilization Management	92	77	8	0	2	5	89%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing/Member Education	77	73	2	0	0	2	97%
Member Grievances and Appeals	62	54	5	2	1	0	87%
Quality Management	86	79	5	0	0	2	94%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	104	1	0	0	0	99%
TOTAL	**722**	**662**	**40**	**6**	**3**	**11**	**93%**

As displayed in the above, 722 elements were reviewed; 40 were determined to be "substantially met," 6 "minimally met," 3 "not met," and 11 were not applicable. The remaining 662 were "fully met." The overall compliance score was 93%.

It is IPRO's and the LDH's expectation that Amerihealth submit a corrective action plan for each of the 49 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that Amerihealth has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Twelve (12) of the 49 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Amerihealth**.**

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

Table 4: Deficient Audit Elements for Amerihealth

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
Core Benefits and Services					
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.	Provider Handbook page 51.	Substantial	Page 51 of the Provider Handbook states that the plan covers behavioral health care in the primary care setting, including screenings. However, there is no evidence in the Handbook regarding how the MCO ensure providers are utilizing screening tools and protocols consistent with industry standards, nor the provision of guidelines, education, training, and consultation for PCPs in terms of behavioral health care. During the onsite interview, the plan stated that the IHCM Program Description further supports this requirement. However, there is no evidence of how the plan provides training and education for providers. <u>Recommendation</u>: Include in the IHCM Program a provision for training PCPs on the use of industry standard tools and protocols for behavioral health screenings. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already begun – to some degree – doing this. Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint Also, please know that ACLA will include this information in the Integrated Health Care Management Program Description
6.4.9.1	The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors,	Provider Handbook, page 51, 67-74.	Substantial	The Provider Handbook outlines which services and screenings should be completed for members. However, there is no evidence in the documentation that addressed this	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.			requirement, specifically the component of the requirement which states "The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care." There is, further, no evidence of MCO efforts to increase these screenings. <u>Recommendation</u>: The MCO should develop a work plan which includes interventions to increase the use of behavioral health screenings in primary care settings. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	begun – to some degree – doing this. Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, or social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	156.900 Continuity for BH Care, pages 1-4. CSoC Workflow	Substantial	Policy 156.900 addresses the requirement on page 4. However, there is no evidence of the MCO's efforts to increase handoffs and assessments. <u>Recommendation</u>: The MCO should develop a work plan which includes interventions to increase communication between PCPs and behavioral health providers. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already begun – to some degree – doing this. Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	UM 905L Emergency Room Services, page 2.	Substantial	UM.905L addresses that services pre-approved by the plan are covered, but does not address that services pre-approved by a network physician are also covered. Recommendation: Include in the UM.905L policy a provision which states that services pre-approved by a network physician are also covered. In response to the draft report, the MCO will update policy to include the required language. The determination remains as "substantial."	ACLA will include such language in the UM.905L policy.
6.35.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	156.202 IHCM Referral Trigger Criteria, pages 2-3.	Substantial	The policy provided as evidence satisfies this requirement in full. Case Management File Review: 4 of 12 Behavioral Health Case Management files have evidence of referrals made, 3 did not need referrals in the review period, and 3 did not have evidence of referrals being made when referrals were necessary.	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	156.900 Continuity for BH Care.	Minimal	The policy provided only states that the rounds are conducted with the ACLA physician. Recommendation: The MCO should include language that indicates that rounds are conducted at least monthly and they are conducted with the BH Case Management team. In response to the draft report, the MCO will update policy to include the required language. The determination remains as "minimal."	ACLA will ensure this language is incorporated into a P&P. Currently, ACLA conducts rounds on a weekly basis. However, during the review period, rounds were conducted on a bi-monthly basis. Please see the attached: • Case Conference April Sign-in Sheet • IHCM Case Conference • IHCM Case

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					Conference Schedule
6.38.2.1	Early identification, through active outreach, of members who have or may have special needs;	156.202 IHCM Referral Trigger Criteria, page 4.	Substantial	The policy does not state when members are identified, only how. <u>Recommendation:</u> The MCO should include in the policy timeframes for the early identification of members with special needs. In response to the draft report, the MCO will update policy to address "early identification." The determination remains as "substantial."	ACLA will incorporate this recommendation into a policy.
6.38.2.4	Development of an individualized treatment plan in accordance with Section 6.19.4;	156.201 Complex Care Management Standards of Practice, page 2.	Substantial	The requirement is stated on page 2 of 156.201. Case Management File Review: 10 of 12 Complex Case Management Files contained an individual treatment plan, one had a care plan dated outside of the review period, and one did not have a care plan for the primary diagnosis. 10 of 12 Behavioral Health Case Management Files contained an individualized treatment plan, while 2 files did not.	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	156.201 Complex Care Management Standards of Practice, page 8.	Substantial	The requirement is stated on page 8 of 156.201. Case Management File Review: 10 of 12 Complex Case Management Files contained evidence of care coordination. For one file, the member had multiple inpatient stays with no evidence of attempts to prevent hospitalization. In another case file, the member was denied for an MRI three times and then opted out of CM, with no evidence that the member received an MRI or other service or had any follow-up. 8 of 12 Behavioral Health Case Management	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				files contained evidence of care coordination. For one file, it was unclear. Three files did not have evidence of care coordination, even though one member had multiple readmissions and two members were not able to obtain necessary MRIs.	
6.38.2.7	Monitoring;	156.201 Complex Care Management Standards of Practice, pages 2 and 4.	Substantial	The requirement is stated on page 2 of 156.201. Case Management File Review: 11 of 12 Complex Case Management files had evidence of monitoring of member outcomes. 8 of 12 Behavioral Health Case Management files had evidence of monitoring of member outcomes, while four files did not.	
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	156.201 Complex Care Management Standards of Practice.	Substantial	The policy addresses establishing a rapport with the member and their families, but does not address whether family members are involved in care planning though during file review, there was documentation of family involvement. Recommendation: The plan should include in the policy, language stating that members' family and/or guardians are involved in the development of care plans. Case Management File Review: 12 of 12 Complex Case Management files have evidence of member and/or authorized family member/guardian involved in treatment care planning. 10 of 12 Behavioral Health Case Management files have evidence of member and/or authorized family member/guardian involved in treatment care planning. In response to the draft report, the MCO will update policy to include language	ACLA will incorporate this language into the relevant policy.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				member/family involvement in care plan development. The determination remains as "substantial."	
Provider Network					
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	PH GeoAccess Report 2016 Q3	Substantial	The requirement is partially addressed in 159.202 Provider Geographical Access Policy, page 2. The access standards delineated in the referenced material does not match the access standards in the contract. The MCO's policy states "All members in urban areas must have access to one (1) hospital within thirty (30) minutes of a member's residence." MCO Onsite Comment: Original contract says minutes and miles. MCO recognizes the contractual standards elsewhere. Although the standards in the policy do not match the standards outlined in the contract, the GEO Access analysis is based on the correct standards. <u>Geo-Access Report Results</u> Urban = 88.9% with access; 11.1% no access Rural = 99.8% with access; 0.2% without access <u>Recommendation</u>: The MCO should revise related policies to ensure access standards are those outlined in the contract; and the MCO should work to improve member access to these services. In response to the draft report, the MCO described actions taken to ensure internal documents match contract requirements. The review determination remains as "substantial."	ACLA recently implemented a change to the Quarter 3 and 4 2016 Behavioral Health Network Development Service Coverage Plan to only references Miles and not Minutes. Quarter 4 Physical Health Network Development Service Coverage Plan has been corrected to reference miles only. Recent revision of 159.202 Provider GeoAccess Standards and Compliance Measures references miles only. Network Development Management Plan for 2017 references Miles and not minutes
7.3.3	Specialists	PH GeoAccess	Minimal	The requirement is addressed in 159.202	ACLA is in the process

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	• Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT – Network Providers by Specialty Type. DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	Report 2016 Q3		Provider Geographical Access Policy, page 2, and in Network Development Plan (20160504). <u>Geo-Access Report Results</u> <u>Deficient Areas</u> **Nuclear Medicine** Urban 82.6% with access; 17.4% without access Rural = 74.5% with access; 25.5% without access **Pediatric Critical Care Medicine** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Pediatric Infectious Disease** Urban = 81.6% with access; 18.4% without access Rural = 74.2% with access; 25.8% without access **Pediatric Rheumatology** Urban = 66.0% with access; 34.0% without access Rural = 53.2% with access; 46.8% without access **<u>Areas meeting standard</u>:** Allergy/Immunology Anesthesiology Audiology Cardiology Chiropractic Dermatology Emergency Medical Endocrinology Gastroenterology Hematology/Oncology Hospice	of finalizing a telemedicine contract. It has been finalized by our legal team and has been sent to the vendor for review and signature. Estimated date of implementation is 4/1/17. ACLA is actively attempting to recruit specialists in areas where there are gaps.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Infectious Disease Neonatology Nephrology Neurology OB/GYN Occupational Therapy Ophthalmology Optician/Optometry Orthopedics Otolaryngology Pathology Pediatric Allergy Pediatric Cardiology Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology/Oncology Pediatric Nephrology Pediatric Pulmonary Pediatric Surgery Physical Therapy Podiatry Pulmonary Medicine Radiology, Diagnostic Radiology, Therapeutic Rheumatology Speech Therapy Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Plastic Surgery, Thoracic Urology MCO Post-Onsite Response: ACLA has not implemented a telemedicine program to meet access requirements. <u>Recommendation:</u> The MCO is aware of the deficiencies in its	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				network but it should continue to work to expand its network, when possible. <u>General Recommendation:</u> All Medicaid MCOs in the state face the same challenges. Perhaps a unified approach with LDH support can work to alleviate the access to care issues in the state and attract more providers to Medicaid managed care. In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "minimal."	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	PH GeoAccess Report 2016 Q3	Minimal	The requirement is partially addressed in 159.202 Provider Geographical Access Policy-BH updated.pdf page 2. The access standards delineated in the referenced material does not match the access standards in the contract. The policy states "All members must have access to lab and radiology service provider within thirty (30) minutes in urban areas and thirty (30) miles in rural areas." MCO Onsite Comment: Original contract says minutes and miles. PH GEO Access Report 2016 Q3, pages 26-27. For some specialties, access standards reported in the GEO Access report differ from the standards delineated in the contract. <u>Geo-Access Report Results</u> Lab and X-Ray Urban = 90.3% with access; 9.7% no access Rural = 77.1% with access; 22.9% without access Radiology	Policies and revised Quarter 3 and 4 reports reference miles and not minutes.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urban = 80.4% with access; 19.6% without access; Rural = 52.2% with access; 47.8% without access Radiology, Diagnostic Urban = 100% with access; MCO standard is 1 provider within 60 miles in urban areas. Rural = 100% with access; MCO standard is 1 provider within 90 miles. Radiology, Therapeutic Urban = 100% with access; MCO standard is 1 provider within 60 miles in urban areas. Rural = 100% with access; MCO standard is 1 provider within 90 miles. <u>Recommendation</u>: The MCO should revise related policies to ensure access standards are those outlined in the contract. The MCO's GEO Access analysis should be based on the standards outlined in the contract; and the MCO should continue to work to improve member access to these services. In response to the draft report, the MCO described actions taken to ensure internal document language match contract language requirements. The review determination remains as "minimal."	
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living	BH GeoAccess Report 2016 Q3	Minimal	The requirement is addressed in 159.202 Provider Geographical Access Policy, page 2; and in BH GEO Access Report 2016 Q3, page 10. There were two reports for APRN. <u>MCO Onsite Response</u>: One report could be for PH or for BH. There was a change in regard to the logic of how the	Appendix UU indicates that Behavioral Health Specialists includes APRNs. "The network standard is applied to this category of providers collectively." Quarter 3 and 4

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	in rural parishes shall not exceed 30 miles for 90% of such members.			report was produced = Parish vs. region. <u>Geo-Access Report Results</u> <u>Deficient Areas</u> **APRN** Rural = 76.7% with access; 23.3% without access **APRN** Rural = 48.1% with access; 51.9% without access **Psychologist, Medical** Rural = 46.5% with access; 53.5% without access **Psychologist, Clinical** Rural = 53.0% with access; 47.0% without access **Psychologist, Developmental** Rural = 0% with access; 100% without access **Psychologist, Other** Rural = 0.6% with access; 99.4% without access **Psychologist, School** Rural = 26.2% with access; 73.8% without access **<u>Areas meeting standard</u>:** BH Specialists Psychiatrists LCSW <u>Recommendation:</u> The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible.	updated gap analysis recognizes ACLA ongoing monitoring of each individual specialist type and need to expand access to these specific specialists which includes psychologists. Providing Telemedicine will also increase access to certain specialists. ACLA is working with a provider to expand services in Regions 3 and 9 which will expand access of psychiatrists and LMHPs.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "minimal."	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is addressed in 159.202 Provider Geographical Access Policy, pp 2; and in BH GEO Access Report 2016 Q3, pp 10. There were two reports for APRN. MCO Onsite Response: One report is for PH or for BH. There was a change in regard to the logic of how the report was produced = Parish vs. region Geo-Access Report Results Deficient Areas **APRN** Urban = 87.2% with access; 12.8% without access **APRN** Urban = 66.3% with access; 33.7% without access **Psychologist, Medical** Urban = 77.1% with access, 22.9% without access **Psychologist, Clinical** Urban = 87.5% with access, 12.5% without access **Psychologist, Developmental** Urban = 0% with access; 100% without access **Psychologist, Other** Urban = 25.8% with access; 74.2% without access **Psychologist, School**	ACLA continues to monitor network gaps and contract providers to fill said gaps.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urban = 22.6% with access; 77.4% without access **<u>Areas meeting standard</u>:** BH Specialists Psychiatrists LCSW <u>Recommendation:</u> The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible. In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "substantial."	
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is partially addressed in BH GEO Access Report 2016 Q3, pp 282. The GEO Access report does not include analysis broken out by adult and adolescent members. Additionally, there is no access analysis for urban areas. <u>Geo-Access Report Results</u> Rural = 84.4% with access; 15.6% without access. <u>MCO Onsite Response</u>: Up until this statutory reporting the State had not requested the breakout for reporting. MCO receives template from state, MCO cannot adjust template. MCO pulls logic based on the template. The change was requested after this review period. <u>Recommendation</u>: The MCO should conduct access analysis for both adults and adolescents using the appropriate access standards; as well as	Recent Revisions of Quarter 3 and 4 for 2016 Behavioral Health Network Development Service Coverage Plan addresses access and gaps for ASAM Level III.3 – Adults, III.5 – Adolescents, III.5-Adults, III.7-Adults, and III.7D Adults. Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent, i.e. ASAM Level III.3/5 requires adolescent members to have access to at least one such provider within 60 miles and within 30 miles for

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				provide analysis for urban areas. In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented rural access data only, making assessment of statewide access impossible. Additionally, the GeoAccess reports were not presented for the adult and adolescent populations. The review determination remains as "substantial."	adults.
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is addressed in BH GEO Access Report 2016 Q3, pp 289. The report does not include access analysis for rural areas. <u>Geo-Access Report Results</u> Urban = With access 52.1%; without access 47.9%. <u>Recommendation:</u> The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible. In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented urban access data only, making assessment of statewide access impossible. The review determination remains as "substantial."	Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent, i.e. ASAM Level III.3/5 requires Adolescent members to have access to at least one such provider within 60 miles and within 30 miles for adults. Appendix UU stipulates the access to be within 60 miles for adults for ASAM III.7 and III.7D. This appendix does not differentiate between rural or urban areas. Contract section 7.3.7 references ASAM levels and access standards for adults and adolescents with no reference to rural or urban parishes. ACLA is working with

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					an existing provider that is opening a new facility in the Northeast. This provider is open to discussions on which populations need this service. A follow up meeting with this provider has been scheduled to address this gap. In addition, ACLA has been discussing gaps with another existing provider and will include these Levels during future discussions to expand scope of their current coverage and to potentially address this gap for adults. ACLA will also aggressively seek additional potential providers to improve access to this care.
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	BH GeoAccess Report 2016 Q3	Substantial	This requirement is addressed in BH GEO Access Report 2016 Q3, pp 294. The report does not include access analysis for rural areas. <u>Geo-Access Report Results</u> Rural = Access 82.2%; Without Access 17.8%. <u>Recommendation:</u> The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible.	Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent, i.e. ASAM Level III.3/5 requires Adolescent members to have access to at least one such provider within 60 miles and within 30 miles for

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented rural access data only, making assessment of statewide access impossible. The review determination remains as "substantial."	adults. Appendix UU stipulates the access to be within 60 miles for adults for ASAM III.7 and III.7D. This appendix does not differentiate between rural or urban areas. Contract section 7.3.7 references ASAM levels and access standards for adults and adolescents with no reference to rural or urban parishes. ACLA is working with an existing provider that is opening a new facility in the Northeast. This provider is open to discussions on which populations need this service. A follow up meeting with this provider has been scheduled to address this gap. In addition, ACLA has been discussing gaps with another existing provider and will include these Levels during future discussions to expand scope of their current coverage and to potentially address this gap for adults.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					ACLA will also aggressively seek additional potential providers to improve access to this care.
7.6.1.1.1	The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH: • Rural Health Clinics (RHCs); • Local Governing Entities; • Federally Qualified health Centers; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy	Network Development Plan	Substantial	The requirement is addressed in Network Development Plan (20160504), pp 17-18, which addresses all BH provider types except MHR agencies and LMHPs. Recommendation: To be fully compliant, the MCO should include in the Network Development Plan, description of its efforts to contract with MHR and LMHPs. In response to the draft report, the MCO described recent and current actions to contract with specific BH providers. The review determination remains as "minimal."	The BH Network Development Service Coverage Plan Quarter 3 states as follows: "ACLA continues to seek adding BHSs to the network to increase access to this provider type in parishes that do not have adequate geographic access, such as Plaquemines and West Feliciana and Regions 7 and 8. ACLA is also addressing a gap of Clinical Psychologists where 54.5% members have access within 30 miles in rural parishes. There is a gap for Licensed Addiction Counselors and Licensed Marriage and Family therapists in rural and urban areas. ACLA will be increasing outreach and recruitment efforts for these specialists. Currently there are 1,247 Licensed Clinical Social Workers in ACLA's network providing services within geographic

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	(CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Mental Health Rehabilitation (MHR) Agencies; Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).				access standards for urban and rural parishes with 96.7% and 98.5% respectfully." The revised BH Network Development Service Coverage Plan Quarter 4 also addresses this gap. "ACLA continues to seek additional BHSs to the network to increase access to this provider type in parishes that do not have adequate geographic access, such as Plaquemines and West Feliciana and Regions 7 and 8. ACLA is also addressing a gap of Clinical Psychologists….There is a gap for Licensed Addiction Counselors and Licensed Marriage and Family therapists in rural and urban areas. ACLA will be increasing outreach and recruitment for these specialists." ACLA continues to accept contract applications from MHR providers. The GeoAccess map for 2016 Quarter 4

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					identifies 165 MHR (legacy) providing access within 60 miles in urban areas and 100% with access within 90 miles in rural areas. In addition to the legacy MHR providers, ACLA has non-legacy MHR (Behavioral Health Rehab Provider Agencies) within network adding 340 providers that facilitate this level of care, which is also available to 100% of members in both urban and rural parishes.
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing	Specialty Care Provider Agreement	Substantial	The requirement is partially addressed in Provider Handbook, page 99. However, there is no mention of the MCO developing a written plan for correction or that LDH shall be notified. <u>Recommendation:</u> The MCO should develop a policy and procedure to ensure the elements of this requirement are followed, and update the Provider Handbook to reflect the process described in this requirement. In response to the draft report, the MCO described actions to update materials to fully address the requirement. The review determination remains as "minimal."	Policy 159.201 has been revised to include this information. Although the Provider Manual partially addresses Mainstreaming, ACLA will revise this section to mirror what has been added in the above mentioned policy.
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including	159.201 Provider Accessibility Standards and Compliance	Substantial	This requirement is partially addressed in 159.201 Provider Accessibility standards and Compliance Policy – BH update, page 5.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the provision of care to members with limited proficiency in English; and			However, it does not explicitly address monitoring adequacy, accessibility and availability related issues faced by members with limited proficiency in English. <u>Recommendation:</u> The policy should be updated to include the missing standard.	
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served	Network Development Plan	Substantial	The requirement is partially addressed in addressed in Network Development Plan (20160504), pages 17 and 28. The referenced material does not include language regarding annual cultural competency trainings of at least 3 hours for MCO staff and BH network providers. <u>Recommendation:</u> The MCO should include the frequency and duration of training into future network development plans and related policy and procedures. In response to the draft report, the MCO will update related policy to include training requirements. The review determination remains as "substantial."	ACLA will include the frequency and duration of training into future network development plans and all related policies.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	(note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.				
Utilization Management					
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	UM.008L Clinical Criteria, pg. 1	Not Met	The contract language is not found in submitted P/P UM.008L Clinical Criteria (pg. 1). The deficiency was discussed with the MCO onsite.	ACLA will amend the UM policies to include the required language.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The required language should be incorporated in to a P/P for UM or P/P Coordination of services. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "not met."	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	Pre-onsite: UM.003L Standard and Urgent Prior Authorization UM.002L Concurrent Review UM Program Description 2015 Post-onsite: UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, 1st paragraph;	Substantial	The P/P UM 003L Standard and Urgent Prior Authorization, Procedure #10, 11 does not contain the contract language, The P/P UM.002L Concurrent Review (pg. 5 4) Procedure #7 does not contain contract language either. The UM Program Description 2015, (pgs. 4-5) contains some but not all of contract language. This issue was discussed onsite with the MCO which submitted P/P UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, 1st paragraph which includes the element language except for stating that EPSDT services may not be limited based on medical necessity or for the purpose of utilization control. Recommendation: The MCO should add contract language related to EPSDT to a UM P/P. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	ACLA will amend its UM policies to include the required language.
8.4.2	The MCO UM Program policies	UM156.401 UM PA	Substantial	The UM156.401 UM PA Workflow for	ACLA will amend its

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert and Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:	Workflow for Managing PA Requests UM Program Description 2015 pg. 4-5		Managing PA Requests addresses this element. The UM Program Description 2015 (pg. 4-5) is not signed or dated; the final page "Approval" is blank. As noted above, the MCO stated onsite that QCCC meeting minutes would be provided to show approval of the UMPD, but the UM Evaluation rather than UMPD was approved during this meeting. <u>Recommendation:</u> The MCO should incorporate the requirement into a P/P for UM or P/P for service authorization. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	UM policies to include the required language.
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	UM.003L Standard and Urgent Prior Authorization	Substantial	The UM.003L Standard and Urgent Prior Authorization, Procedure #1, (pg. 3) addresses this element, but does not address incorporation into grievance procedures. The member Handbook (pg. 33) addresses this element. Onsite the MCO submitted P/P UM Program Description 2016, Authorizations section, page 15, 2nd paragraph; page 16, paragraphs 3-5 which does not address grievance procedure incorporation. A review of the Member Grievances Policy and Procedure (pg. 3) define service authorizations as an "action" and explicitly excludes them from the Grievance procedures. <u>Recommendation</u>: The MCO should clarify its policy and ensure that service authorization requests are	Melissa: Not sure why we would do this. I thought all service auth requests had to come from a provider.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				included in grievance procedures. In response to the draft report, the MCO did not submit additional evidence or commit to addressing the recommendation. The determination remains as "substantial."	
8.4.4.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	2015 UM Program Description, pg. 16	Substantial	The 2015 UM Program Description, (pg. 16) is in draft (tracked changes) form, and is unsigned. It states that: Medical Necessity decisions made by the ACLA Medical Director or designee are based on the Department of Health and Hospital's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the Member's benefits, medical expertise, ACLA Medical Necessity guidelines (as outlined in Policy UM.008L: *Clinical Criteria*), DHH contract, the Louisiana Behavioral Health Partnership (LBHP) Services Definition Manual and/or published peer-review literature. At the discretion of the ACLA Medical Director/designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting Practitioner/Provider may provide input to the decision. The ACLA Medical Director or designee makes the final decision. The MCO stated onsite that all denials are made by a General Practitioner, and post-onsite, provided QCCCI meeting minutes as evidence of QAPI Committee approval of the 2015 UM PD, which was not found in the minutes.	ACLA will clarify this responsibility and also incorporate it into a P&P.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The MCO should clarify whether LMHPs conduct reviews or only conducts them at the discretion of a general practitioner Medical Director. The MCO should revise policies if necessary, or submit existing policies to meet this requirement. In response to the draft report, the MCO will clarify and update policies. The review determination remains as "substantial."	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	Pre-onsite: N/A – ACLA submits encounter data per Molina specifications. Concurrent utilization reviews are not a reportable field on the encounter layout Post-onsite: UM.002L Concurrent Review Policy	Substantial	A P/P for UM was not submitted for this element. After discussing this issue onsite the MCO submitted the P/P UM.002L Concurrent Review Policy in which the following contract language was not found: "However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment. " Recommendation: The MCO should include the missing contract language in the P/P. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	ACLA will amend its UM policies to include the requested language.
8.4.4.4.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. • Ensure that PRTF certification,	UM.004L PRTF Authorization Process Procedure: Sections 6 and 7, pgs. 3-4 UM Program Description 2015, pgs. 5-7 UM.010L	Substantial	Tracking reports were not submitted for review. The UM Program Description 2015, (pgs. 5-7) only contains 48 hour timeline for PRTF approval notification, but not include immediate notification for denials. The MCO provided QCCC meeting minutes as	ACLA will develop a tracking report and a P&P regarding timely notification to the provider.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	including the independent certification, are forwarded to the admitting facility. • Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal, and the process to do so. • Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. • Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. • Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. • Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.	Timeliness of UM Decisions, pg. 2		evidence of acceptance of the 2015 UM PD post-onsite, in which approval of the UMPD was not found. UM.010L Timeliness of UM Decisions, (pg. 2) does not contain language about notifying the provider within 48 hours. After discussing the issues onsite, the MCO stated they don't give the provider notice, although they do FAX the dates of service approved. The MCO submitted a BH UM PRTF Denial Letter Example, and BH UM Approval Member Letter Example. <u>Recommendation</u>: The MCO should develop a Tracking report and a P/P that includes policy regarding timely notification to the provider. In response to the draft report, the MCO will develop a tracking report and policy. The review determination remains as "substantial."	
8.5.4.2	The MCO shall not require	UM.003L Standard	Substantial	The P/P UM.003L Standard and Urgent Prior	ACLA will clarify its

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	and Urgent Prior Authorization Attachment A, pg. 8		Authorization Attachment A, (pg. 8) states authorization is required for newborn deliveries exceeding 48 hours (vaginal) and 96 hours (c-section). The MCO stated onsite that their policy mirrors CMS language that after 48 hours a delivery is not "normal." <u>Recommendation:</u> The MCO's policy should be consistent with LDH regulations. In response to the draft report, the MCO will update policies to ensure consistency with LDH regulations. The review determination remains as "substantial."	policy to ensure consistency with LDH regulations.
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	2016 QAPI Program Description14 (bullet # 9)	Substantial	PCP/BN profiling reports were not submitted for review. The contract language is not stated in 2016 QAPI Program Description (pg. 14, bullet # 9). This issue was discussed onsite with the MCO which in response submitted the LA HEDIS Summary, HEDIS IDSS, and Provider Performance Report. The Provider Performance Report is redacted, and does not provide evidence of profiling of specialized behavioral health providers (ADHD medication is the only BH measure). The HEDIS IDSS reports several BH measures (including SMD, SMC, AMM, SSD, AMM, but does not report FUH), and does not provide individual provider results. The only BH measure found in the LA HEDIS summary is ADD. It doesn't appear that any of the BH measures are used to profile providers. <u>Recommendation</u>:	ACLA has already begun developing this profile/report, which will be in place by Q2 2017.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				The MCO should develop profile reports of its specialized BH providers. In response to the draft report, the MCO has stated that it has have already initiated the development of the profile report. The review determination remains as "substantial."	
8.12.3.1	Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	UM.904L Authorizations for Out-of-Network Practitioners and Providers Procedure #3, pg. 3	Not Met	The contract language was not found in the P/P UM.904L Authorizations for Out-of-Network Practitioners and Providers, (pg. 3). The MCO did not provide a response for this deficiency discussed onsite. Follow-up is required. <u>Recommendation</u>: The MCO should develop a mechanism to identify and evaluate member utilization of out of network providers. In response to the draft report, the MCO states that referrals are not required for a member to access care from a provider other than his/her PCP, however, the response does not address the identification and evaluation of member out-of-network provider referral utilization by in-network PCPs. The determination remains as "not met."	This information was previously captured in the 072 report. That report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH. Since then, LDH has not required or provided a template to capture such. It should also be noted that referrals are not required for a member to access care from a provider other than his/her PCP. It should also be noted that referrals are not required for a member to access care from a provider other than his/her PCP.
Marketing/Member Education					
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on	ACLA Member Handbook	Substantial	The requirement is partially addressed in ACLA Member Handbook, page 40. Language regarding "religious grounds" is not found in the Member Handbook. MCO Onsite Comment: There are non-discriminatory clauses throughout the Member Handbook. However, the clauses do	The member has the right to refuse treatment for any reason, which includes religious grounds. Furthermore, this same language was found fully compliant in the

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	religious grounds;			not specifically state "religious grounds." Recommendation: Include explicit language in Member Handbook regarding right to refuse medical services due to religious reasons. In response to the draft report, the MCO will update the member handbook to include the refusal of treatment for religious beliefs. The review determination remains as "substantial."	previous 2015 IPRO readiness review of this provision. Per your recommendation, we will add this clarification to the next revision of our handbook; however, we request reconsideration of this determination as the current language includes religious grounds although not explicitly stated.
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	ACLA 124.12.019 (Member Rights & Responsibilities)	Substantial	The requirement is partially addressed in ACLA 124.12.019; in Member Handbook, pages 39-41; in Provider Handbook, Section X: Member Rights & Responsibilities; and Logisticare Contract. While the contract includes explicit language about PHI and general language that refers to member rights and responsibilities, e.g., timely rides, clean vehicles, etc., the contract does not state that a copy of the official member rights and responsibilities are shared with Logisticare. MCO Onsite Comment: Member Rights and Responsibilities are available to Member Services staff via an online help tool; they also have access to Member Rights and Responsibilities. MCO associates use the Policy in their everyday work. Recommendation: MCO should share Member Rights and Responsibilities with all vendors and	ACLA will distribute the Member Rights and Responsibilities to subcontractors who work directly with members.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				subcontractor who provide direct services to members. In response to the draft report, the MCO will distribute Member Rights and Responsibilities to subcontractors who work directly with members. The review determination remains as "substantial."	
Member Grievances and Appeals					
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Substantial	The requirement is addressed in Med. Mgmt. Appeals Policy and Procedure, pg. 6. The required language, "The MCO must inform the member of the limited time available for this in the case of expedited resolution is not found in the Member Handbook and the process for notifying members of opportunity to provide evidence was not submitted for review (no template letters provided). File Review Results: Of the ten (10) appeal files reviewed onsite, there was evidence in all ten (10) files that the member was informed of the right to provide evidence, allegations of fact or law, in person as well as in writing. Recommendation: The MCO should add the missing required language to the Member Handbook. In response to the draft report, the MCO will update the member handbook to include the required language. The review determination remains as "substantial."	ACLA will address by adding the required language to the member handbook.
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals	Med. Mgmt. Appeals Policy and Procedure, pg. 8	Minimal	The element is addressed in Med. Mgmt. Appeals Policy and Procedure, pg. 8 and in the Member Handbook.	ACLA is moving to update the denial template to include

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.			File Review Results: Of the ten (10) appeal files reviewed onsite, all ten (10) files were missing evidence that the member was informed of the right to request case files before the appeals process. Recommendation: The MCO should update the denial letter template to include language that informs members of the right to request case files and other related documents prior to initiating the appeal process. In response to the draft report, the MCO will update the denial template to include the required language. The review determination remains as "minimal."	this language.
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	(LOB 2100) New Hire Training Agenda Monthly Meeting Sign-In Sheet	Minimal	The LOB 2100 New Hire Training Agenda is undated, and is corporate-wide training in FL. Monthly Meeting Sign-In Sheets do not indicate that LA Plan staff was trained. This issue was discussed onsite and the MCO did not provide a response. Recommendation: The MCO should provide evidence of training LA staff to meet this requirement. In response to the draft report, the MCO submitted a PowerPoint Presentation that only provides a high-level grievance overview for a corporate-wide meeting. Training materials or evidence of training on member and provider rights was not submitted for review. The review determination remains as "minimal."	Evidence of grievance training: Please see slides 8-9 of the Town Hall PowerPoint. Evidence of appeals training: The previously submitted FL monthly meeting sign-in sheets capture associate participation and serve as documentation of ongoing appeals training. It should be noted that it is this Florida staff that handles all appeals on behalf of ACLA. Please know that ACLA is working on appeals and grievance refresher training that

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					will be included in our next Town Hall presentation.
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Med. Mgmt. Appeals Policy and Procedure UM.010L Timeliness of UM Decisions	Substantial	The contract language relative to standard authorizations was not found in the submitted P/Ps. A template Notice of Decision to Extend Timeframe was not submitted for review. In response to discussing these issues onsite, the MCO submitted the following statement: The language is found in the attached appeals policy. See *Timing of Notice*, page 6. <u>File Review Results</u>: None of the fifteen (15) grievance files reviewed onsite involved an extension. <u>Recommendation</u>: The language in the submitted appeals policy (See *Timing of Notice*, page 6) refers to Appeals, not to standard authorizations as required for this element. A P/P for Notice of Action or P/P for Handling Extensions should be provided for compliance. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	ACLA will ensure this language is incorporated into a UM policy.
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.5.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.	UM 003L Standard and Urgent Prior Authorization, Procedure #8 pg. 4	Substantial	The contract language relative to standard authorizations was not found in the submitted P/P. In response to discussing this deficiency onsite, the MCO submitted the following statement: The language is found in the attached appeals policy. See *Timing of Notice*, page 6. <u>Recommendation</u>: The language in the submitted appeals policy	ACLA will ensure this language is covered in a UM policy.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				(See *Timing of Notice*, pg. 6) refers to Appeals, not to standard authorizations as required for this element. A P/P for Notice of Action should be provided for compliance. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition Grievances.** The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	Member Grievances Policy and Procedure, pg. 7 Med. Mgmt. Appeals Policy and Procedure, pg. 6 Member Handbook, pg. 45	Substantial	The contract language is stated in both submitted Grievance and Appeals Policies and in the Member handbook. <u>File Review Results</u>: Of the fifteen (15) grievance files reviewed onsite, thirteen (13) had evidence of an acknowledgment of receipt in writing within 5 days while two did not.	
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Med. Mgmt. Appeals Policy and Procedure, pg 6	Not Met	The required language is not found in Med. Mgmt. Appeals Policy and Procedure, pg 6, and the process for notifying members of the opportunity to present evidence was not submitted for review. The MCO did not provide a response during the discussion onsite. <u>Recommendation:</u> The MCO should provide the process for notifying members of the opportunity to present evidence. In response to the draft report, the MCO will update the denial template to include the required language. The review determination remains as "note met."	ACLA is moving to update the denial template to include this language.
13.7.5	**Authority to File** The Medicaid member or their	Member Handbook, pg 45	Substantial	The element language is stated in the Member Handbook; however, "no follow up	The policy will be amended to include

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.			required" was not found in the Appeals Policy. In response to discussing this issue onsite the MCO stated: The auditor's suggestion will be taken into consideration. The MCO indicated that it will amend the policy to include the language which captures the intent of the contract. However, ACLA allows members to file an appeal orally or in writing, without requiring additional follow up. <u>Recommendation</u>: The policy should be amended to include the language as stated by the MCO. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	this language.
Quality Management					
14.1.6	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	Pre-onsite: 2016 QAPI Program Description, Physician Feedback, Pg. 28 LARC Fax Blast, LARC Reimbursement Rate, Pg. 1 IHCM Sickle Cell Blueprint, Program Goals, Pg.2 ADHD PIP, Entire Document, all pages Post-onsite: 2016 IHCM Program	Substantial	The following deficiencies in the submitted 2016 QAPI Program Description were discussed with the MCO onsite: Physician Feedback, Pg. 28 does not address LARC, pain management for sickle cell, or ADHD behavioral therapy. The need for a dated and signed Sickle Cell Blueprint was also discussed. In response, the MCO submitted a revised 2016 QAPI Program Description that contains all contract language for this element as well as an undated, unsigned IHCM Program Description that addresses sickle cell care. <u>Recommendation</u>: The MCO submitted a revised 2016 QAPI Program Description outside of the review period to meet this requirement. The 2016	Pursuant to Section 4.5.1 of the LDH contract: Reviewed policies shall be dated and signed by the MCO's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. The QAPI meeting

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Description Appendix I – Dated Sickle Cell Blueprint per request 2016 QAPI Program Description (v. 2) Added language to QAPI PD for future reference		IHCM Program Description Appendix I – should be signed and dated. In response to the draft report, the MCO suggested that evidence of compliance with the requirement could be found in the QAPI meeting minutes. However, evidence of approval during the review period of the revised 2016 program description, its attachments or policies related to this element could not be found in the submitted QAPI meeting minutes. The determination remains as "substantial."	minutes produced to evidence approval of the program description also cover adoption of its attachments. ACLA requests reconsideration of this determination.
14.1.10	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.	Pre-onsite: 2016 QAPI Program Description Post-onsite: 2016 QAPI Program Description (v. 2) 14.1.10 HEDIS 2015 Disparities Data 14.1.10 HEDIS 2015 Disparities Report 14.1.10 HEDIS 2015 Disparities Memo	Substantial	The 2016 QAPI Program Description Pg. 39 addresses only the policy of collecting data. This issue was discussed onsite with the MCO. In response, the MCO submitted a revised 2016 QAPI Program Description inclusive of the element language as well as a HEDIS Disparities data, report, and a memo which meet the requirement but was completed after the review period. <u>Recommendation</u>: The MCO submitted a revised 2016 QAPI Program Description outside of the review period to meet this requirement. In response to the draft report, the MCO suggests that evidence of compliance with this requirement is found in previously submitted documents. However, this element specifically is to be "part of the QAPI program description" which was revised to meet the element after the review period. The review determination remains as "substantial."	The HEDIS 2015 Race, Ethnicity & Language memo, data and report to the QAPI Committee is from the audit time period and evidences ACLA's compliance with this measure. ACLA requests reconsideration of this determination.
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and	2016 QAPI Program Description	Substantial	The 2016 QAPI Program Description addresses this element. Quality Management Roles & Responsibilities	This contract provision does not require the level of detail (i.e., education or

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	their responsibilities;			Pg. 23-27 lists QAPI program staff titles and their responsibilities but not their specific required educational background or credentials (except for MD for Medical Director), i.e., RN, LSW, or B.S. It does note the training they receive relative to their job. <u>Recommendation:</u> The MCO should provide a description of the credentials of the QAPI staff and/or an organizational chart that would include this information. In response to the draft report, the MCO clarified the requirement. As a result, the recommendation has been revised to the following: the MCO should clarify with LDH whether training for this element includes personal level of educational training and credentials of the QAPI staff, or whether broad training descriptions for all staff are sufficient. The review determination remains as "substantial."	credentials) requested in the recommendation. As the specific person filling each role may change on occasion, it is not recommend to include person details on the individual. We believe the contract provision is met via the inclusion of the title, responsibilities and training of QAPI members and overview of committee structure. For these reasons, we request reconsideration of this determination.
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the	Pre-onsite: 141 ACLA 2015 (MAC Annual Plan) Post-onsite: 039 ACLA 2015Q4 – 2016Q2 (MAC Meeting Minutes).	Substantial	The 141 ACLA 2015 (MAC Annual Plan) Pg. 1 addresses this element, but does not state that at least one family member/caregiver of a child with special health care needs shall have representation on the committee. Post onsite, the MCO submitted MAC meeting minutes for two meetings in the RP (11-5-15, and 2-23-16). No members are identified as being in attendance on the 2-23-16 minutes, and the 11-5-15 minutes identify one member as a dial-in attendee, although whether this member is a family member/caregiver of a child with special health care is not indicated. <u>Recommendation</u>:	ACLA will update the MAC annual plan with this language. While we have special needs advocacy groups and community partners on our MAC, we have been unable to recruit a family member / caregiver of a special needs child. We are working diligently to fulfill this requirement.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	membership.			The MCO should add the contract language, "at least one family member/caregiver of a child with special health care needs shall have representation on the committee" to the MAC Annual plan and should provide evidence of the Member Advisory Council composition in compliance with this requirement.	
14.5.6.	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	MAC Webpage ACLA MAC Meeting Invite	Substantial	The meeting minutes for September 15, 2015 and November 5, 2015, are available in English on the MCO MAC webpage. <u>Recommendation</u>: All agenda and MAC council minutes for the RP should be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	ACLA will add the MAC agendas to our member website in English and Spanish. We will translate our MAC minutes into Spanish and post to our website as well.
Fraud, Waste and Abuse					
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Agency Collaboration & Rights of Access, page 9.	Substantial	The requirement is stated on page 10 of the Compliance Program Description. However, it is not stated that requests for information will be compiled in the form and language requested. <u>Recommendation</u>: The MCO should add this language to the Program Description and ensure that MCO staff are aware of this component of the requirement. In response to the draft report, the MCO submitted as evidence of compliance, a response that the MCO submitted to an OIG request for data. While this evidence demonstrates partial compliance, it does not replace the need to have the required language incorporated into the MCOs Compliance Program Description. The determination remains as "substantial."	ACLA has demonstrated compliance with this section via numerous responses to requests during the audit period, as evidenced by the attached OIG Pharmacy Data Request email. We will include this clarification in our 2017 Compliance Program Description; however, we request reconsideration of this determination based on the attached proof of compliance.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.				

Section 3: MCO Final Audit Tools

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

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**				
6.4.5 6.4.5.1	**Permanent Supportive Housing** DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Bayou Health members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388. Overall management of the PSH program is centralized within DHH and final approval for members to participate in PSH is made by the DHH PSH program staff. For the Louisiana PSH program, the MCO shall:				
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member Handbook, page 20 2016 IHCM Program Description, pages 10-11, 38-39 PSH Workflow.	Full	On page 20 of the Member Handbook, under the bullet for *Mental health and substance use services for adults*, the plan states that certain members may be eligible for PSH. In the IHCM Program Description, on page 10, it state that a goal of the Program is to "identify, enroll, and link members with Serious and Persistent Mental Illness (SPMI)…" and "Assist/arrange an initial assessment… and annual re-assessment… for the SHCN population, including but not limited to members who may be	

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				eligible for Permanent Supportive Housing…" Additionally, the plan provided a screenshot of the PSH Workflow, which shows the process for identifying and outreaching these members.	
6.4.5.1.2	Assist members in completing the PSH program application;	156.900 Continuity for BH Care, page 3 PSH Workflow	Full	Policy 156.900 outlines the responsibilities of the Behavioral Care Manager, which includes assisting with PSH applications. The PSH Workflow chart also addresses this requirement.	
6.4.5.1.3	Within one (1) working day of request by designated DHH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	PSH Workflow PSH Communication	Full	The PSH Workflow contains a step which addresses this requirement. Additionally, the plan provided a sample of an email correspondence between DHH PSH staff and plan staff regarding eligibility assessment, determination, and recertification.	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the DHH PSH program manager; and	The template has not been made available to the MCO by LDH.	Full	The MCO stated that DHH had not yet provided a reporting template, and therefore did not submit any documentation that satisfied this requirement. During the onsite interview, the MCO clarified that it does keep track of members who are referred for the PSH program through its internal referral system. Recommendation: The MCO should operationalize this requirement through a policy and develop a monthly outreach reporting system internally until such time as LDH provides a reporting format.	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:				

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4.5.2.1	Identify a PSH program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Liaison List	Full	The MCO provided a contact list, which included the main PSH liaison, as well as a secondary liaison.	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.	Provider Handbook page 51.	Substantial	Page 51 of the Provider Handbook states that the plan covers behavioral health care in the primary care setting, including screenings. However, there is no evidence in the Handbook regarding how the MCO ensure providers are utilizing screening tools and protocols consistent with industry standards, nor the provision of guidelines, education, training, and consultation for PCPs in terms of behavioral health care. During the onsite interview, the plan stated that the IHCM Program Description further supports this requirement. However, there is no evidence of how the plan provides training and education for providers. Recommendation: Include in the IHCM Program a provision for training PCPs on the use of industry standard tools and protocols for behavioral health screenings. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already begun – to some degree – doing this. Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint Also, please know that ACLA will include this information in the Integrated Health Care Management Program Description

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	
6.4.9.1	The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider Handbook, page 51, 67-74.	Substantial	The Provider Handbook outlines which services and screenings should be completed for members. However, there is no evidence in the documentation that addressed this requirement, specifically the component of the requirement which states "The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care." There is, further, no evidence of MCO efforts to increase these screenings. Recommendation: The MCO should develop a work plan which includes interventions to increase the use of behavioral health screenings in primary care settings. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already begun – to some degree – doing this. Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, or social delays, as well as child	156.900 Continuity for BH Care, pages 1-4. CSoC Workflow	Substantial	Policy 156.900 addresses the requirement on page 4. However, there is no evidence of the MCO's efforts to increase handoffs and assessments.	While ACLA will certainly continue to work to bridge the divide between PCPs and behavioral health, ACLA has already begun – to some degree – doing this.

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	maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.			Recommendation: The MCO should develop a work plan which includes interventions to increase communication between PCPs and behavioral health providers. In response to the draft report, the MCO submitted a presentation which included an overview of the integrated healthcare model, as well as the PHQ-9 and the Patient Stress Questionnaire; however, it is unclear if this document is provided to PCPs or if the PCPs are trained on these screening tools. The determination remains as "substantial."	Please see the attached: • Integrated Healthcare and The Medical Neighborhood PowerPoint
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	Network Development Plan, page 14. 156.211 Threats to Members Health and Safety, pages 1-6. Crisis Intervention Workflow (24/7/365) Letter of Intent ACLA Crisis Intervention Center	Full	The MCO provided evidence of its Crisis Intervention Workflow both in flowchart form and through 156.211. Additionally, within its Network Development Plan, the plan outlined current and future collaborations, including the Crisis Intervention Center, Seaside Health Care, Acadian Ambulance, and Volunteers of America.	
6.8	**Emergency Medical Services and Post Stabilization Services**				
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency	UM 905L Emergency Room Services, page 2.	Full	Page 2 of UM.905L states that the plan covers emergency services without prior authorization. Page 4 of the same policy states that members may go to out-of-network facilities for emergency services if they need to.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.				
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service areas use of emergency services as defined in the Glossary.	Member Handbook for Integrated Health Services, page 31. BH Member Handbook, page 23.	Full	Page 31 of the Member Handbook for Integrated health Services instructs members to utilize the nearest ER if they have a medical emergency away from home, and to call their PCP or the Nurse Line if they need medical advice.	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	UM 905L Emergency Room Services, page 1.	Full	The requirement is stated on page 1 of UM.905L.	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	UM 905L Emergency Room Services, page 2.	Full	The Provider Handbook notes that the plan reimburses all emergency medicine at the contracted rate. There are no limitations noted.	
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	UM 905L Emergency Room Services, page 2.	Full	Page 2 of UM.905L states that the attending physician(s) makes the final determination on whether a member is stable for transfer/discharge.	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	UM 905L Emergency Room Services, page 2.	Full	The requirement is stated verbatim on page 2 of UM.905L.	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies	2016 IHCM Program Description, pages 52-53, 55.	Full	The IHCM Program Description outlines an extensive and robust plan to reduce non-emergent ER usage. The plan has outlined several distinct interventions targeted at	

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	of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.			members, providers, and the plan in order to reduce ER usage and increase the use of appropriate avenues of care.	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Provider Handbook, page 52.	Full	The Provider Handbook describes "appropriate level of care" for admission from the ER to inpatient services. However, it only states that "Members are encouraged to contact their PCP…about conditions that may/may not require ER treatment." In the IHCM Program Description, however, on pages 52-56, the plan outlines its intervention strategy for reducing ED usage, in which the plan describes methods for member and provider education concerning appropriate use of the ED.	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposed of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.	2016 IHCM Program Description, pages 52-56. ER Utilization Report	Full	The MCO provided an exhaustive and detailed ER Utilization Report, presenting information broken down by diagnosis codes, days of the week, facilities, parishes, time of day, etc. In UM.905L, the "test for appropriateness" is addressed on page 1.	
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member Handbook for Integrated Health Services, page 8.	Full	The requirement is stated on page 8 of the Member Handbook.	
6.8.2 6.8.2.1	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii), and (iii), the MCO is financially responsible for post stabilization care services obtained within or outside the MCO that are:				

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	UM 905L Emergency Room Services, page 2.	Substantial	UM.905L addresses that services pre-approved by the plan are covered, but does not address that services pre-approved by a network physician are also covered. Recommendation: Include in the UM.905L policy a provision which states that services pre-approved by a network physician are also covered. In response to the draft report, the MCO will update policy to include the required language. The determination remains as "substantial."	ACLA will include such language in the UM.905L policy.
6.8.2.1.2	Not pre-approved by a network physician provider or other MCO representative, but:	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 2 of UM.905L.	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; or	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 2 of UM.905L.	
6.8.2.1.2.2	Administered to maintain, improve, or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 2 of UM.905L.	
6.8.2.2	The MCO's financial responsibility for post-stabilization that is has not pre-approved ends when:				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on pages 2-3 of UM.905L.	

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6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 3 of UM.905L.	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; ;or	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 3 of UM.905L.	
6.8.2.2.4	The member is discharged.	UM 905L Emergency Room Services, page 2.	Full	The requirement is addressed on page 3 of UM.905L.	
6.19	**Services for Special Populations**				
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:				
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;				
6.19.1.2	Individuals with intravenous drug use;				
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders;				
6.19.1.4	Substance using women with dependent children;				
6.19.1.5	Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;				
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and				
6.19.1.7	Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.				
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). DHH may also identify special healthcare members and provide that information to the MCO. The LMHP of PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members	156.201 Complex Care Management Standards of Practice, page 9.	Full	There was no evidence within the provided document (156.201) that satisfies this requirement. During the onsite interview, the plan stated that the PQ039 reports demonstrate the identification of members with special healthcare needs within 90 days, as well as the	

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	within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.			administration of assessments of these members within 90 days of identification. The PQ039 report does contain this information; however, there is no other evidence that this is a policy of the plan. Recommendation: The MCO should operationalize this requirement by developing either a policy or a work plan for the reporting of identification of members with special needs and subsequent referral to case management.	
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: • The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, DHH approved, guidelines for SHCN criteria. • MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. • Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. • Members may be identified by DHH and that information provided to the MCO.	156.201 Complex Care Management Standards of Practice, page 8.	Full	The requirement is addressed on page 1 of 156.202.	
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan and a person-centered plan of care. The individualized treatment plans must be:	156.201 Complex Care Management Standards of Practice, page 9.	Full	The requirement is addressed on page 9 of 156.201.	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in	156.900 Continuity for BH Care, page 7.	Full	The requirement is stated on page 7 of 156.900.	

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	consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Adult Approval Child Approval			
6.19.4.2	In compliance with applicable quality assurance and utilization management standards.	156.201 Complex Care Management Standards of Practice	Full	A review of related quality assurance and utilization management policies and procedures and case files demonstrates compliance with the requirement.	
6.19.4.3	SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a person-centered plan of care that includes all medically necessary services including specialized behavioral health services identified in the member's treatment plan.	156.201 Complex Care Management Standards of Practice, page 2.	Full	The requirement is addressed on page 2 of 156.201.	
6.27	**Care Management**				
6.27.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	156.201 Complex Care Management Standards of Practice, page 4. Member Handbook page 2.	Full	Policy 156.201 defines "care management," while the Member Handbook, page 2, states that every member has a primary care provider.	
6.27.2 6.27.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	156.201 Complex Care Management Standards of Practice, pages 1-2.	Full	The requirement is addressed throughout 156.201, which outlines the process of coordination of care through the PCP.	
6.27.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	124.12.012 Contact Center, pages 3-4.	Full	Policy 124.12.012 states that Member Services is available 24/7/365 for members, as well as the 24/7 Nurse Line.	
6.27.2.3	Care coordination and referral activities, in person or telephonically depending on	156.201 Complex Care Management Standards of	Full	Policy 156.201 provides an overview of the structure and purpose of the	

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	member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	Practice, pages 1-2.		Care Management Program.	
6.27.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff.	2016 IHCM Program Description, Appendix D, page 1.	Full	The requirement is stated verbatim on pages 77-78 (Appendix D) of the IHCM Program Description.	
6.29	**Care Coordination, Continuity of Care, and Care Transition**				
6.29.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services that are reimbursed on a fee-for-service basis by DHH or DHH's dental benefit program manager. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 1. 156.301 Care Transition—Plan or Provider Change, page 1. 2016 Adult Medicaid Executive Summary 2016 Child Medicaid wCCC Executive Summary	Full	The policies that were provided are designed to ensure the continuity of care for members and to coordinate behavioral health services. The plan also provided the 2016 CAHPS reports for the adult and child populations, which also include action plans for low-scoring measures.	

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	primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.				
6.29.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 4.	Full	The requirement is stated on page 4 of 156.701.	
6.29.2	The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:				
6.29.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Member Handbook for Integrated Health Services, page 27.	Full	Page 2 of the Member Handbook states that every plan member will have a PCP.	
6.29.2.2	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	156.900 Continuity for BH Care, page 4.	Full	The requirement is stated on page 4 of 156.900.	
6.29.2.3	Coordinate care for out-of-network services, including specialty care services;	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 5.	Full	The requirement is stated on page 5 of 156.701.	
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 1.	Full	The requirement is stated on page 1 of 156.701.	
6.29.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 1.	Full	The requirement is stated on page 1 of 156.701.	
6.29.2.6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	156.701 Coordination with other Healthcare and Non-Healthcare Services, pages 1-2.	Full	The requirement is stated on page 1 of 156.701.	
6.29.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	156.800 Care Transition—Discharge Planning.	Full	The MCO provided Policy 156.800, which outlines the discharge planning program.	
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-	P&P 151.103 Behavioral Health Discharge Meds.	Full	The MCO provided Policy 156.800, which outlines the discharge	

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	discharge care as appropriate, including aftercare appointments following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and/or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	156.800 Care Transition—Discharge Planning. ACLA BH Pharmacy Discharge Template UM BH IP Discharge Review Workflow.		planning program, as well as Policy 151.103, which outlines the plan's procedures for ensuring medications are authorized prior to discharge. The plan also provided the Discharge Review Workflow, which included directions/steps for the discharge planning process and screenshots of the plan's database used to plan patients discharged.	
6.29.2.8.1	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral heath facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings.).	UM BH IP Discharge Review Workflow, page 8.	Full	The requirement is addressed on page 8 of the UM BH IP Discharge Workflow.	
6.29.2.8.2	Care managers follow-up with members with a behavioral health-related diagnosis within 72 hours following discharge.	156.800 Care Transition—Discharge Planning, page 2.	Full	The requirement is stated on page 1 of 156.800 (5th bullet).	
6.29.2.8.3	Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	156.800 Care Transition—Discharge Planning, page 2.	Full	The requirement is stated on page 1 of 156.800 (10th bullet).	
6.29.2.9	Document authorized referrals in its utilization management system; and	UM.904L Authorization of Out-of-Network Practitioners and Providers, page 3.	Full	The requirement is addressed throughout UM.904L.	
6.29.2.10	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.	UM.706L Continuity of Care Policy, page 3.	Full	The requirement is stated on page 3 of UM.706L.	
6.29.2.11	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending	156.701 Coordination with other Healthcare and Non-Healthcare Services, page 4.	Full	Requirement is stated on page 4 of 156.701.	

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	court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing.				
6.29.2.12	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	156.800 Care Transition—Discharge Planning, page 2.	Full	Requirement is stated verbatim on page 2 of 156.800.	
6.35	**Continuity for Behavioral Health Care**				
6.35.1	The PCP shall provide basic behavioral health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	Provider Handbook, pages 18-19, 51.	Full	The requirement is addressed on pages 19 and 51 of the Provider Handbook.	
6.35.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addition are healthcare issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.	156.202 IHCM Referral Trigger Criteria.	Full	The MCO provided the 2016 IHCM Program Description, which addresses this requirement. Case Management File Review: one of 12 Behavioral Health Case Management files had evidence of accessible and comprehensive prevention and treatment services. It was not applicable to the other 11 cases.	
6.35.3	In any instance when the member presents to the network provider, including calling the	156.900 Continuity for BH Care, page 8.	Full	The requirement is stated on page 8 of 156.900.	

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	MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.				
6.35.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	UM.905L Emergency Room Services, page 2.	Full	The requirement is addressed in UM.905L.	
6.35.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	156.201 Complex Care Management Standards of Practice, page 8. 156.204 Member Contact by Care Management Programs, pages 1-2.	Full	Policy 156.201 states that it is documented when members agree to enroll in case management. Policy 156.204 outlines the procedure for contacting members for care management engagement to gain permission to coordinate care/gain members' approval to be involved with case management.	
6.35.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	156.202 IHCM Referral Trigger Criteria, pages 2-3.	Substantial	The policy provided as evidence satisfies this requirement in full. Case Management File Review: 4 of 12 Behavioral Health Case Management files have evidence of referrals made, 3 did not need referrals in the review period, and 3 did not have evidence of referrals being made when referrals were necessary.	
6.35.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities, and agencies and require complex coordination of benefits and services.	156.202 IHCM Referral Trigger Criteria, pages 2-3.	Full	The requirement is addressed by the list of the types of members to whom the provided policy (156.202) applies.	
6.35.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	156.102—Orientation and Training of Care Management Care Coordination Staff, pages 1-3. Mental Illness in Adults	Full	Policy 156.102 outlines the training procedures, both at initial hire and annually thereafter.	

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6.35.9 6.35.9.1.1 6.35.9.1.2 6.35.9.1.3 6.35.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medial disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.	Provider Handbook, pages 21 and 39.	Full	The requirement is addressed on page 39 of the Provider Handbook.	
6.35.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistance, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of the patients.	Network Development Plan, page 23. Medical Neighborhood PowerPoint	Full	The requirement is addressed on pages 23-24 of the Network Development Plan.	
6.35.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Behavioral Health Provider Training Plan Version 1.0, page 6.	Full	The requirement is addressed in the provided document, on page 6.	
6.35.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	BH Member Handbook, page 21.	Full	Both the Member and the Provider Handbooks explain the proper use of emergency services.	
6.35.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	2016 IHCM Program Description, page 54.	Full	The requirement is addressed on page 54 of the IHCM Program Description.	
6.35.9.1.9	Ensuring continuity and coordination of care	156.701 Coordination with	Full	The requirement is addressed	

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	for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	other Healthcare and Non-Healthcare Services. 156.900 Continuity for BH Care.		through 156.900.	
6.35.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	156.201 Complex Care Management Standards of Practice, page 7.	Full	The requirement is stated on page 7 of 156.201.	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	Network Development Plan, page 23. Medical Neighborhoods PowerPoint	Full	The Network Development Plan outlines the PCHM model, which includes the introduction of the Medical Neighborhood. Providers who are recognized by the PCHM program can receive an enhanced payment.	
6.35.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	156.900 Continuity for BH Care, page 4.	Full	The requirement is stated on page 4 of 156.900.	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	156.900 Continuity for BH Care.	Minimal	The policy provided only states that the rounds are conducted with the ACLA physician. Recommendation: The MCO should include language that indicates that rounds are conducted at least monthly and they are conducted with the BH Case Management team. In response to the draft report, the MCO will update policy to include the required language. The determination remains as "minimal."	ACLA will ensure this language is incorporated into a P&P. Currently, ACLA conducts rounds on a weekly basis. However, during the review period, rounds were conducted on a bi-monthly basis. Please see the attached: • Case Conference April Sign-in Sheet • IHCM Case Conference • IHCM Case Conference Schedule
6.35.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with DHH representatives for the purpose of coordination and communication.	156.900 Continuity for BH Care, page 4.	Full	The requirement is stated on page 4 of 156.900.	
6.38	**Case Management (CM)**				
6.38.1	The MCO shall develop and implement a case management program through a process which provides that appropriate and	156.201 Complex Care Management Standards of Practice, pages 1-2.	Full	Policy 156.201 describes the criteria for enrollment in the case management program on page 1.	

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	medically-related services, social services, and basic and specialized behavioral health services are identified, planned, obtained, and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.			Page 2 addresses the integration of member and case manager reviews of member strengths, and references are made throughout the policy to review and update of member strengths.	
6.38.2	Case Management program functions shall include but not be limited to:				
6.38.2.1	Early identification, through active outreach, of members who have or may have special needs;	156.202 IHCM Referral Trigger Criteria, page 4.	Substantial	The policy does not state when members are identified, only how. Recommendation: The MCO should include in the policy timeframes for the early identification of members with special needs. In response to the draft report, the MCO will update policy to address "early identification." The determination remains as "substantial."	ACLA will incorporate this recommendation into a policy.
6.38.2.2	Assessment of a member's risk factors;	156.201 Complex Care Management Standards of Practice, pages 1-2, 4.	Full	The requirement is stated on page 4 of 156.201.	
6.38.2.3	Education regarding patient-centered medical home and referral to a medical home when appropriate;	156.201 Complex Care Management Standards of Practice, page 2.	Full	The requirement is stated on page 2 of 156.201.	
6.38.2.4	Development of an individualized treatment plan in accordance with Section 6.19.4;	156.201 Complex Care Management Standards of Practice, page 2.	Substantial	The requirement is stated on page 2 of 156.201. Case Management File Review: 10 of 12 Complex Case Management Files contained an individual treatment plan, one had a care plan dated outside of the review period, and one did not have a care	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				plan for the primary diagnosis. 10 of 12 Behavioral Health Case Management Files contained an individualized treatment plan, while 2 files did not.	
6.38.2.5	Referrals and assistance to ensure timely access to providers;	156.201 Complex Care Management Standards of Practice, page 4.	Full	The requirement is stated on page 4 of 156.201.	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	156.201 Complex Care Management Standards of Practice, page 8.	Substantial	The requirement is stated on page 8 of 156.201. Case Management File Review: 10 of 12 Complex Case Management Files contained evidence of care coordination. For one file, the member had multiple inpatient stays with no evidence of attempts to prevent hospitalization. In another case file, the member was denied for an MRI three times and then opted out of CM, with no evidence that the member received an MRI or other service or had any follow-up. 8 of 12 Behavioral Health Case Management files contained evidence of care coordination. For one file, it was unclear. Three files did not have evidence of care coordination, even though one member had multiple readmissions and two members were not able to obtain necessary MRIs.	
6.38.2.7	Monitoring;	156.201 Complex Care Management Standards of Practice, pages 2 and 4.	Substantial	The requirement is stated on page 2 of 156.201. Case Management File Review: 11 of 12 Complex Case Management files had evidence of monitoring of member outcomes. 8 of 12 Behavioral Health Case Management files had evidence of	

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				monitoring of member outcomes, while four files did not.	
6.38.2.8	Continuity of care; and	156.201 Complex Care Management Standards of Practice, pages 8-9.	Full	The requirement is stated on page 9 of 156.201.	
6.38.2.9	Follow-up and documentation.	156.201 Complex Care Management Standards of Practice.	Full	The requirement is stated on pages 6 and 9 of 156.201.	
6.38.3	Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19. A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.	BH UM Notification of BH Services Engaged Members Workflow 156.201 Complex Care Management Standards of Practice.	Full	Policy 156.201 states that the SHCN populations are targeted for case management. Case Management File Review: 10 of 12 Behavioral Health Case Management files a plan of care for SHCN members.	
6.38.3.1	The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.	156.201 Complex Care Management Standards of Practice.	Full	Policy 156.201 outlines the case management and care plan development procedure. The plan also provided the comprehensive checklist for case management.	
6.39	**Case Management (CM) Policies and Procedures**				
6.39.0	The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually	041 ACLA 2015 (CCMP P&Ps—Program Eval.)	Full	The MCO provided evidence of correspondence between the plan and DHH.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:				
6.39.1	A process to offer voluntary participation in the Case Management Program to eligible members;	156.201 Complex Care Management Standards of Practice.	Full	The requirement is addressed in 156.201.	
6.39.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	156.202 ICHM Referral Trigger Criteria	Full	The requirement is addressed in 156.202.	
6.39.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: • Reproductive aged women with a history of prior poor birth outcomes; and • High risk pregnant women.	156.202 ICHM Referral Trigger Criteria	Full	The requirement is addressed in 156.202.	
6.39.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	156.201 Complex Care Management Standards of Practice. Member Handbook	Full	The requirement is addressed in 156.202. Case Management File Review: 12 of 12 Complex Case Management files contained an individual needs assessment and diagnostic assessment, 11 files contained established long and short term treatment objectives, 3 have care plan revisions (6 did not need to be revised) 10 of 12 Behavioral Health Case Management files contained an individual needs assessment and diagnostic assessment and established long and short term treatment objectives. 1 file had care plan revisions (6 did not need to be revised).	
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	156.201 Complex Care Management Standards of Practice.	Substantial	The policy addresses establishing a rapport with the member and their families, but does not address whether family members are involved in care planning though during file review, there was documentation of family	ACLA will incorporate this language into the relevant policy.

Core Benefits and Services					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				involvement. Recommendation: The plan should include in the policy, language stating that members' family and/or guardians are involved in the development of care plans. Case Management File Review: 12 of 12 Complex Case Management files have evidence of member and/or authorized family member/guardian involved in treatment care planning. 10 of 12 Behavioral Health Case Management files have evidence of member and/or authorized family member/guardian involved in treatment care planning. In response to the draft report, the MCO will update policy to include language member/family involvement in care plan development. The determination remains as "substantial."	
6.39.6	Procedures and criteria for making referrals to specialists and subspecialists;	156.201 Complex Care Management Standards of Practice.	Full	The requirement is addressed in 156.201.	
6.39.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	156.301 Care Transition-Plan or Provider Change 156.201 Complex Care Management Standards of Practice.	Full	Policy 156.301 outlines the procedures for transitioning members between providers.	
6.39.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	156.201 Complex Care Management Standards of Practice.	Full	The requirement is stated in 156.201. Case Management File Review: 12 of 12 Complex Case Management files have evidence of coordination with the plan's Chronic Care Management Program.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				3 of 12 Behavioral Health Case Management files have evidence of coordination with the plan's Chronic Care Management Program (5 were not applicable).	
6.40	**Case Management Reporting Requirements**				
6.40	The MCO shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	039 ACLA 2016 Q2 (CM Report)	Full	The MCO provided email communication with DHH and the attachments that the plan sent, including the case management report.	
6.40.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.40.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.40.3	Number of member identified with potential special healthcare needs that self-refer;	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.40.4	Number of members with potential special healthcare needs identified by the MCO;	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.40.5	Number of members in the lock-in program;	165 ACLA 2016 07 (lock-in Report)	Full	The MCO submitted the Q2 report, which included this information.	
6.40.6	Number of member identified with special healthcare needs by the PASRR Level II authority;	317 ACLA 2016 (PASRR Report)	Full	The MCO submitted the Q2 PASRR report, which included this information.	
6.40.7	Number of members with assessments completed; and	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.40.8	Number of members with assessments resulting in a referral for Case Management.	039 ACLA 2016 Q2 (CM Report)	Full	The MCO submitted the Q2 CM report, which included this information.	
6.41	**Chronic Care Management Program (CCMP)**				
6.41.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive Heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle	156.201 Complex Care Management Standards of Practice. 2016 IHCM Program	Full	The MCO provided evidence of its programs for chronic disease management in the appendices of the IHCM Program Description.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	Description.			
6.41.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.	2016 IHCM Program Description	Full	The MCO provided evidence of its programs for chronic disease management in the appendices of the IHCM Program Description.	
6.41.4	The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	041 ACLA 2015 (CCMP P&Ps Program Eval.)	Full	The MCO provided evidence of correspondence concerning this requirement to DHH.	
6.41.4.1	Include the definition of the target population;	2016 IHCM Program Description	Full	The MCO provided evidence of the definition of the target populations in the appendices of the IHCM Program Description.	
6.41.4.2	Include member identification strategies, i.e. through encounter data;	2016 IHCM Program Description	Full	The member identification strategies are included in the documentation.	
6.41.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	2016 IHCM Program Description	Full	The MCO provided evidence of the use of evidence-based guidelines.	
6.41.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	2016 IHCM Program Description	Full	The requirement is addressed throughout the ICHM Program Description.	
6.41.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	2016 IHCM Program Description	Full	The requirement is addressed throughout the ICHM Program Description.	
6.41.4.6	Include methods for informing and educating members and providers;	156.300 CM Care Coordination Blended Model for Disease Management.	Full	The MCO provided evidence of education via the Member and Provider Handbooks, Member and Provider web portals, new provider orientation, the Welcome Packet	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				for New Members, IHCM Program monthly mailings, newsletters, etc.	
6.41.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	156.300 CM Care Coordination Blended Model for Disease Management.	Full	The MCO provided evidence of education via the Member and Provider Handbooks, Member and Provider web portals, new provider orientation, the Welcome Packet for New Members, IHCM Program monthly mailings, newsletters, etc.	
6.41.4.8	Address co-morbidities through a whole-person approach;	156.300 CM Care Coordination Blended Model for Disease Management.	Full	The requirement is addressed throughout 156.300.	
6.41.4.9	Identify members who require in-person case management services and a plan to meet this need;	2016 IHCM Program Description, page 40.	Full	The requirement is addressed in the Program Description.	
6.41.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	156.300 CM Care Coordination Blended Model for Disease Management.	Full	Policy 156.300 describes the plan's procedures for disease management and case management coordination.	
6.41.4.11	Include Program Evaluation requirements.	156.201 Complex Care Management Standards of Practice, page 2.	Full	The requirement is addressed in 156.201.	
6.43	**CCMP Reporting Requirements**				
6.43.1	The MCO shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	042 ACLA 2016 Q2 (CCMP Report)	Full	The MCO provided the CCMP report with quarterly breakdowns of enrolled members.	
6.43.2	The CCMP reports shall contain at a minimum:				
6.43.2.1	Total number of members;	042 ACLA 2016 Q2 (CCMP Report)	Full	There is a tab for each specific condition, and each contains columns for the total number of members.	
6.43.2.2	Number of member enrolled in each stratification level for each chronic condition; and	042 ACLA 2016 Q2 (CCMP Report)	Full	Each tab contains columns for each stratification level and the total number of members in each.	
6.43.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	042 ACLA 2016 Q2 (CCMP Report)	Full	There is a tab for members who were disenrolled and why they were disenrolled.	
6.43.3 6.43.3.1	The MCO shall submit the following report annually: Chronic Care Management Program	041 ACLA 2015 (CCMP P&Ps—Program Eval.)	Full	The MCO provided the 2015 year-end report, as well as evidence of	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	evaluation.			correspondence with LDH.	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
7.1	**General Provider Network Requirements**				
7.1.1	The MCO must maintain a network that ensures, at a minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Provider Manual	Full	The requirement is addressed in Network Development Plan (20160504), pages 15 and 29; and in GEO Access Report 2016 Q3. MCO Onsite Response: On an annual basis the MCO compares itself to commercial plans in the area for opportunities to expand contracting. A corporate tool is used to compare commercial payers and Medicaid providers in the state.	
7.1.2	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Provider Manual	Full	The requirement is addressed in Network Development Plan (20160504), page 31.	
7.1.3	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.				
7.1.4	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Network Development Plan UM.904L Authorization of Out-of-Network Practitioners and Providers 2016	Full	The requirement is addressed in Member Handbook, page 16; and in Network Development Plan (20160504), pages 7 and 30.	
7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural	Provider Manual 7.1.6 REL Data - - Collection Script Lookup and FAQ's	Full	The requirement is addressed in 7.1.6 Attestation Provider Cultural Competency Training; in Provider Handbook, page 28; and in 159.201 Provider Accessibility Standards and	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.	7.1.6 Attestation - - Provider Cultural Competency Training		Compliance Policy, page 4.	
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:				
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	159.201 Provider Accessibility Standards and Compliance	Full	The requirement is addressed in 159.201 Provider Accessibility Standards and Compliance, page 2; in Provider Handbook, page 22; and in Member Handbook, pages 12 and 21.	
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in 159.201 Provider Accessibility Standards and Compliance, page 2; in Provider Handbook, page 22; and in Member Handbook, pages 12 and 21.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in 159.201 Provider Accessibility Standards and Compliance, page 2; in Provider Handbook, pages 22; and in Member Handbook, page 12.	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, page 22; in 159.201 Provider Accessibility Standards and Compliance Policy, page 2; and in Member Handbook, pages 12 and 21.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, page 26; in 159.201 Provider Accessibility Standards and Compliance Policy, page 2. The standard is not reported in the Member Handbook with other appointment standards. The MCO	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				did not submit evidence that this information is shared with members. MCO Post-Onsite Response: Communication to members is not a contract requirement. This element is met via our 159.201 (Provider Accessibility Standards) P&P and monitored via ACLA's annual accessibility survey, as well as our regular reporting of Appendix UU to LDH. Recommendation: Though not a specific requirement in this regulation, the MCO should ensure all appointment standards are communicated to members and network providers.	
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, page 26; and in 159.201 Provider Accessibility Standards and Compliance Policy, page 4. The standard is not reported in the Member Handbook with other appointment standards. The MCO did not submit evidence that this information is shared with members. MCO Post-Onsite Response: Communication to members is not a contract requirement. This element is met via our 159.201 (Provider Accessibility Standards) P&P and monitored via ACLA's annual accessibility survey, as well as our regular reporting of Appendix UU to LDH.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: Though not a specific requirement in this regulation, the MCO should ensure all appointment standards are communicated to members and network providers.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, pp 26; 159.201 Provider Accessibility Standards and Compliance Policy, page 3; and in Member Handbook, page 23.	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, pages 17-18; and in 159.201 Provider Accessibility Standards and Compliance Policy, page 4.	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is partially addressed in Member Handbook, page 12. The requirement is partially addressed in 159.201 Provider Accessibility Standards and Compliance Policy, pages 3-4; however it does not mention the toll-free telephone number. The requirement is partially addressed in Provider Handbook,	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	number at all times.			page 19; however it does not mention the toll-free telephone number. MCO Post-Onsite Comment: 7.2.1.12 does not apply to providers. This is a plan requirement. Providers are not required to have access to a toll-free number. ACLA has a 24/7 toll-free nurse call line to support this provision. See page 55 of previously produced member handbook. Recommendation: The MCO should update the Member Handbook to include language regarding provider responsibility related to the elements of this requirement.	
7.3	**Geographic Access Requirements**				
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as determined by DHH approved mapping software (*e.g.* GeoAccess). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in 159.202 Provider Geographical Access Policy, page 2. MCO Onsite Response: In 2012, 2013 and 2014 the MCO submitted an attestation because it could not identify specific providers in specific areas. Currently, there are some providers that are unwilling to contract due to reimbursement rates. There are no recent requests for exceptions. Recommendation: Though the MCO is aware of this problem, it should continue to work to recruit providers to its network and submit an exception report for	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				those areas where the MCO is not able to successfully recruit to maintain compliance with contract regulations.	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers • Travel distance for members living in rural parishes shall not exceed 30 miles; and • Travel distance for members living in urban parishes shall not exceed 10 miles	PH GeoAccess Report 2016 Q3	Full	The requirement is addressed in 159.202 Provider Geographical Access Policy, page 2; and in PH GEO Access Report 2016 Q3, pages 2-3. Geo-Access Report Results Urban = 98.2% with access; 1.8% without access Rural = 100% with access	
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	PH GeoAccess Report 2016 Q3	Substantial	The requirement is partially addressed in 159.202 Provider Geographical Access Policy, page 2. The access standards delineated in the referenced material does not match the access standards in the contract. The MCO's policy states "All members in urban areas must have access to one (1) hospital within thirty (30) minutes of a member's residence". MCO Onsite Comment: Original contract says minutes and miles. MCO recognizes the contractual standards elsewhere. Although the standards in the policy do not match the standards outlined in the contract, the GEO Access analysis is based on the correct standards. Geo-Access Report Results Urban = 88.9% with access; 11.1% no access Rural = 99.8% with access; 0.2% without access	• ACLA recently implemented a change to the Quarter 3 and 4 2016 Behavioral Health Network Development Service Coverage Plan to only references Miles and not Minutes. • Quarter 4 Physical Health Network Development Service Coverage Plan has been corrected to reference miles only. • Recent revision of 159.202 Provider GeoAccess Standards and Compliance Measures references miles only. • Network Development Management Plan for 2017 references Miles and not minutes

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The MCO should revise related policies to ensure access standards are those outlined in the contract; and the MCO should work to improve member access to these services. In response to the draft report, the MCO described actions taken to ensure internal documents match contract requirements. The review determination remains as "substantial".	
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT – Network Providers by Specialty Type. DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	PH GeoAccess Report 2016 Q3	Minimal	The requirement is addressed in 159.202 Provider Geographical Access Policy, page 2, and in Network Development Plan (20160504). Geo-Access Report Results Deficient Areas **Nuclear Medicine** Urban 82.6% with access; 17.4% without access Rural = 74.5% with access; 25.5% without access **Pediatric Critical Care Medicine** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Pediatric Infectious Disease** Urban = 81.6% with access; 18.4% without access Rural = 74.2% with access; 25.8% without access **Pediatric Rheumatology**	• ACLA is in the process of finalizing a telemedicine contract. It has been finalized by our legal team and has been sent to the vendor for review and signature. Estimated date of implementation is 4/1/17. • ACLA is actively attempting to recruit specialists in areas where there are gaps.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urban = 66.0% with access; 34.0% without access Rural = 53.2% with access; 46.8% without access **<u>Areas meeting standard</u>:** Allergy/Immunology Anesthesiology Audiology Cardiology Chiropractic Dermatology Emergency Medical Endocrinology Gastroenterology Hematology/Oncology Hospice Infectious Disease Neonatology Nephrology Neurology OB/GYN Occupational Therapy Ophthalmology Optician/Optometry Orthopedics Otolaryngology Pathology Pediatric Allergy Pediatric Cardiology Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology/Oncology Pediatric Nephrology Pediatric Pulmonary Pediatric Surgery Physical Therapy Podiatry Pulmonary Medicine Radiology, Diagnostic Radiology, Therapeutic Rheumatology	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Speech Therapy Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Plastic Surgery, Thoracic Urology MCO Post-Onsite Response: ACLA has not implemented a telemedicine program to meet access requirements. Recommendation: The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible. General Recommendation: All Medicaid MCOs in the state face the same challenges. Perhaps a unified approach with LDH support can work to alleviate the access to care issues in the state and attract more providers to Medicaid managed care. In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "minimal".	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	PH GeoAccess Report 2016 Q3	Minimal	The requirement is partially addressed in 159.202 Provider Geographical Access Policy-BH updated.pdf page 2. The access standards delineated in the referenced material does not match the access standards in the contract. The policy states "All	Policies and revised Quarter 3 and 4 reports reference miles and not minutes.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				members must have access to lab and radiology service provider within thirty (30) minutes in urban areas and thirty (30) miles in rural areas". MCO Onsite Comment: Original contract says minutes and miles. PH GEO Access Report 2016 Q3, pages 26-27. For some specialties, access standards reported in the GEO Access report differ from the standards delineated in the contract. <u>Geo-Access Report Results</u> Lab and X-Ray Urban = 90.3% with access; 9.7% no access Rural = 77.1% with access; 22.9% without access Radiology Urban = 80.4% with access; 19.6% without access; Rural = 52.2% with access; 47.8% without access Radiology, Diagnostic Urban = 100% with access; MCO standard is 1 provider within 60 miles in urban areas. Rural = 100% with access; MCO standard is 1 provider within 90 miles. Radiology, Therapeutic Urban = 100% with access; MCO standard is 1 provider within 60 miles in urban areas. Rural = 100% with access; MCO standard is 1 provider within 90	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				miles. Recommendation: The MCO should revise related policies to ensure access standards are those outlined in the contract. The MCO's GEO Access analysis should be based on the standards outlined in the contract; and the MCO should continue to work to improve member access to these services. In response to the draft report, the MCO described actions taken to ensure internal document language match contract language requirements. The review determination remains as "minimal".	
7.3.5 7.3.5.1 7.3.5.2	Pharmacies • Travel distance shall not exceed 10 miles in urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	PH GeoAccess Report 2016 Q3	Full	The requirement is addressed in PH GEO Access Report 2016 Q3, page 442-443. Geo-Access Report Results Urban = 97.8% with access; 2.2% without access Rural = 100% with access	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers • Travel distance shall not exceed 10 miles in urban areas; and • Travel distance shall not exceed 30 miles in rural areas.	PH GeoAccess Report 2016 Q3	Full	PH GEO Access Report 2016 Q3, pp 34-35. Geo-Access Report Results Urban = 89.7% with access; 10.3% without access Rural = 98.7% with access; 1.3% without access Recommendation: The MCO should update related policies to include access standards for this service.	
7.3.7	**Specialized Behavioral Health Providers**	BH GeoAccess Report 2016 Q3	Minimal	The requirement is addressed in	• Appendix UU indicates that

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.3.7.1	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members.			159.202 Provider Geographical Access Policy, page 2; and in BH GEO Access Report 2016 Q3, page 10. There were two reports for APRN. MCO Onsite Response: One report could be for PH or for BH. There was a change in regard to the logic of how the report was produced = Parish vs. region. Geo-Access Report Results Deficient Areas **APRN** Rural = 76.7% with access; 23.3% without access **APRN** Rural = 48.1% with access; 51.9% without access **Psychologist, Medical** Rural = 46.5% with access; 53.5% without access **Psychologist, Clinical** Rural = 53.0% with access; 47.0% without access **Psychologist, Developmental** Rural = 0% with access; 100% without access **Psychologist, Other** Rural = 0.6% with access; 99.4% without access **Psychologist, School** Rural = 26.2% with access; 73.8% without access	Behavioral Health Specialists includes APRNs. "The network standard is applied to this category of providers collectively." Quarter 3 and 4 updated gap analysis recognizes ACLA ongoing monitoring of each individual specialist type and need to expand access to these specific specialists which includes psychologists. • Providing Telemedicine will also increase access to certain specialists. • ACLA is working with a provider to expand services in Regions 3 and 9 which will expand access of psychiatrists and LMHPs.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Areas meeting standard: BH Specialists Psychiatrists LCSW Recommendation: The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible. In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "minimal".	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is addressed in 159.202 Provider Geographical Access Policy, pp 2; and in BH GEO Access Report 2016 Q3, pp 10. There were two reports for APRN. MCO Onsite Response: One report is for PH or for BH. There was a change in regard to the logic of how the report was produced = Parish vs. region Geo-Access Report Results Deficient Areas **APRN** Urban = 87.2% with access; 12.8% without access **APRN** Urban = 66.3% with access; 33.7% without access **Psychologist, Medical** Urban = 77.1% with access, 22.9% without access **Psychologist, Clinical**	ACLA continues to monitor network gaps and contract providers to fill said gaps.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urban = 87.5% with access, 12.5% without access **Psychologist, Developmental** Urban = 0% with access; 100% without access **Psychologist, Other** Urban = 25.8% with access; 74.2% without access **Psychologist, School** Urban = 22.6% with access; 77.4% without access **Areas meeting standard:** BH Specialists Psychiatrists LCSW Recommendation: The MCO is aware of the deficiencies in its network but it should continue to work to expand its network, when possible. In response to the draft report, the MCO described actions taken to address deficient areas. The review determination remains as "substantial".	
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is partially addressed in BH GEO Access Report 2016 Q3, pp 282. The GEO Access report does not include analysis broken out by adult and adolescent members. Additionally, there is no access analysis for urban areas. Geo-Access Report Results Rural = 84.4% with access; 15.6%	• Recent Revisions of Quarter 3 and 4 for 2016 Behavioral Health Network Development Service Coverage Plan addresses access and gaps for ASAM Level III.3 – Adults, III.5 – Adolescents, III.5-Adults, III.7-Adults, and III.7D Adults. • Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent,

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				without access. MCO Onsite Response: Up until this statutory reporting the State had not requested the breakout for reporting. MCO receives template from state, MCO cannot adjust template. MCO pulls logic based on the template. The change was requested after this review period. Recommendation: The MCO should conduct access analysis for both adults and adolescents using the appropriate access standards; as well as provide analysis for urban areas. In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented rural access data only, making assessment of statewide access impossible. Additionally, the GEOAccess reports were not presented for the adult and adolescent populations. The review determination remains as "substantial".	i.e. ASAM Level III.3/5 requires adolescent members to have access to at least one such provider within 60 miles and within 30 miles for adults.
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	BH GeoAccess Report 2016 Q3	Substantial	The requirement is addressed in BH GEO Access Report 2016 Q3, pp 289. The report does not include access analysis for rural areas. Geo-Access Report Results Urban = With access 52.1%; without access 47.9%. Recommendation: The MCO is aware of the	• Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent, i.e. ASAM Level III.3/5 requires Adolescent members to have access to at least one such provider within 60 miles and within 30 miles for adults. Appendix UU stipulates the access to be within 60 miles

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				deficiencies in its network but it should continue to work to expand its network, when possible. In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented urban access data only, making assessment of statewide access impossible. The review determination remains as "substantial".	for adults for ASAM III.7 and III.7D. This appendix does not differentiate between rural or urban areas. Contract section 7.3.7 references ASAM levels and access standards for adults and adolescents with no reference to rural or urban parishes. • ACLA is working with an existing provider that is opening a new facility in the Northeast. This provider is open to discussions on which populations need this service. A follow up meeting with this provider has been scheduled to address this gap. In addition, ACLA has been discussing gaps with another existing provider and will include these Levels during future discussions to expand scope of their current coverage and to potentially address this gap for adults. • ACLA will also aggressively seek additional potential providers to improve access to this care.
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	BH GeoAccess Report 2016 Q3	Substantial	This requirement is addressed in BH GEO Access Report 2016 Q3, pp 294. The report does not include access analysis for rural areas. Geo-Access Report Results Rural = Access 82.2%; Without Access 17.8%. Recommendation: The MCO is aware of the deficiencies in its network but it should continue to work to expand	• Appendix UU from the state does not address access by urban or rural distinction but only by adult vs. adolescent, i.e. ASAM Level III.3/5 requires Adolescent members to have access to at least one such provider within 60 miles and within 30 miles for adults. Appendix UU stipulates the access to be within 60 miles for adults for ASAM III.7 and III.7D. This appendix does not

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				its network, when possible. In response to the draft report, the MCO clarifies that the distance requirement does not distinguish between rural and urban access; however the MCO presented rural access data only, making assessment of statewide access impossible. The review determination remains as "substantial".	differentiate between rural or urban areas. Contract section 7.3.7 references ASAM levels and access standards for adults and adolescents with no reference to rural or urban parishes. • ACLA is working with an existing provider that is opening a new facility in the Northeast. This provider is open to discussions on which populations need this service. A follow up meeting with this provider has been scheduled to address this gap. In addition, ACLA has been discussing gaps with another existing provider and will include these Levels during future discussions to expand scope of their current coverage and to potentially address this gap for adults. • ACLA will also aggressively seek additional potential providers to improve access to this care.
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in BH GEO Access Report 2016 Q3, pp 218-219.	
7.3.7.7	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in 159.202 Provider Geographical Access Policy, pp 2. MCO Onsite Response: No exceptions requested for BH.	
7.3.7.8	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in 159.202 Provider Geographical Access Policy, pp 2.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.4.1	Provider to Member Ratios The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in Appendix UU.	PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in Network Development Plan (20160504), pp 32.	
7.5	**Monitoring and Reporting on Provider Networks**				
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	159.201 Provider Accessibility Standards and Compliance	Full	The requirement is addressed in 159.201 Provider Accessibility Standards and Compliance Policy; in Provider Handbook, page 22; in Member Handbook, pages 12 and 21; in Network Development Plan (20160504), page 31; and in Morpace After-Hours Survey Results.pdf. The appointment standards are included in the Provider Handbook and Member Handbook which are posted on the MCO's website: http://amerihealthcaritasla.com/pdf/provider/resources/manual/handbook.pdf http://amerihealthcaritasla.com/pdf/member/handbook/english.pdf Recommendation: The Morpace After Hours Survey results are difficult to understand. It is recommended that the report be revised to include overall pass and fail rates.	
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall	PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in Network Development Plan (20160504), pp 30; and in 159.202 Provider Geographical Access Policy. MCO submitted screenshot of ACLA	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.			Network Adequacy FTP upload as evidence.	
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.	PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	MCO submitted screenshots of ACLA Network Adequacy FTP upload and PCP-ERRO file notification in response to weekly PCP-BATCH linkage file as evidence.	
7.6	**Provider Enrollment**				
7.6.1 7.6.1.1	**Provider Participation -** The MCO must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs); all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services) and all providers approved by the DHH PSH program to provide tenancy and	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pp 17-18.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	pre-tenancy supports for the Louisiana Permanent Supportive Housing program.				
7.6.1.1.1	The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH: • Rural Health Clinics (RHCs); • Local Governing Entities; • Federally Qualified health Centers; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Mental Health Rehabilitation (MHR) Agencies; • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).	Network Development Plan	Substantial	The requirement is addressed in Network Development Plan (20160504), pp 17-18. Which addresses all BH provider types except MHR agencies and LMHPs. Recommendation: To be fully compliant, the MCO should include in the Network Development Plan, description of its efforts to contract with MHR and LMHPs. In response to the draft report, the MCO described recent and current actions to contract with specific BH providers. The review determination remains as "minimal".	• The BH Network Development Service Coverage Plan Quarter 3 states as follows: "ACLA continues to seek adding BHSs to the network to increase access to this provider type in parishes that do not have adequate geographic access, such as Plaquemines and West Feliciana and Regions 7 and 8. ACLA is also addressing a gap of Clinical Psychologists where 54.5% members have access within 30 miles in rural parishes. There is a gap for Licensed Addiction Counselors and Licensed Marriage and Family therapists in rural and urban areas. ACLA will be increasing outreach and recruitment efforts for these specialists. Currently there are 1,247 Licensed Clinical Social Workers in ACLA's network providing services within geographic access standards for urban and rural parishes with 96.7% and 98.5% respectfully." • The revised BH Network Development Service Coverage Plan Quarter 4 also addresses this gap. "ACLA continues to seek additional BHSs to the network to increase access to this provider type in parishes that do not have adequate

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					geographic access, such as Plaquemines and West Feliciana and Regions 7 and 8. ACLA is also addressing a gap of Clinical Psychologists….There is a gap for Licensed Addiction Counselors and Licensed Marriage and Family therapists in rural and urban areas. ACLA will be increasing outreach and recruitment for these specialists." • ACLA continues to accept contract applications from MHR providers. The GeoAccess map for 2016 Quarter 4 identifies 165 MHR (legacy) providing access within 60 miles in urban areas and 100% with access within 90 miles in rural areas. In addition to the legacy MHR providers, ACLA has non-legacy MHR (Behavioral Health Rehab Provider Agencies) within network adding 340 providers that facilitate this level of care, which is also available to 100% of members in both urban and rural parishes.
7.6.1.2	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pp 17. <u>MCO Post-Onsite Response</u>: This falls outside of the audit period as the contract defines STP as follows: Significant Traditional Provider (STP) – Those Medicaid enrolled	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				providers that provided the top eighty percent (80%) of Medicaid services for the MCO-eligible population in the base year of 2013. STP contracting efforts were completed in 2013.	
7.6.1.3	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pp 17. <u>Post-Onsite MCO Comment</u>: This element falls outside of the audit period as the contract defines STP as follows: Significant Traditional Provider (STP) – Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services for the MCO-eligible population in the base year of 2013. STP contracting efforts were completed in 2013.	
7.6.1.4	The provisions above (7.6.1.2 and 7.6.1.3) do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pp 18.	
7.6.1.5	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of	7.6.1.5 Denial Sample Letter Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 18.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	its decision [42 CFR 438.12(a)(1)].				
7.6.1.6	The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Network Development Plan	Full	This requirement is addressed in Network Development Plan (20160504), pages 23 and 34. There is evidence that the ACLA network development plan includes establishing relationships with community organizations and partnering with providers. ACLA participates with other Medicaid MCOs and the LDH in the conduct of collaborative Performance Improvement Projects, including ADHD and perinatal care.	
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	CP 210.101 – Organizational Provider Certification Policy CP 210.102 – Ongoing Monitoring CP 210.104 – Credentialing-Recredentialing of Practitioners	Full	The requirement is addressed in Network Development Plan (20160504), page 18.	
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	CP 210.104 – Credentialing-Recredentialing of Practitioners 7.6.3 7.6.3.1 – TEMPLATE Non-Discriminatory Form	Full	The requirement is addressed in Network Development Plan (20160504), page 18.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Network Development Plan	Full	The requirement is addressed in Provider Handbook, pp 23-24; and in Network Development Plan (20160504), page 20.	
7.6.3.3	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider. The MCO shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.	CP 210.102 – Ongoing Monitoring	Full	The requirement is addressed in Network Development Plan (20160504), pp 21; and in 159.301 Provider Termination Process, page 6.	
7.6.3.4	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 21; in 159.301 Provider Termination Process, page 6, and Member Notice of Provider Term.	
7.7	**Mainstreaming**				
7.7.1	DHH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 18.	
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 18.	
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 18.	
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 18.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	manner, or at a different time from that provided to other members, other public or private patients, or the public at large.				
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 18.	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing	Specialty Care Provider Agreement	Substantial	The requirement is partially addressed in Provider Handbook, page 99. However, there is no mention of the MCO developing a written plan for correction or that LDH shall be notified. Recommendation: The MCO should develop a policy and procedure to ensure the elements of this requirement are followed, and update the Provider Handbook to reflect the process described in this requirement. In response to the draft report, the MCO described actions to update materials to fully address the requirement. The review determination remains as "minimal".	• Policy 159.201 has been revised to include this information. • Although the Provider Manual partially addresses Mainstreaming, ACLA will revise this section to mirror what has been added in the above mentioned policy.
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Specialty Care Provider Agreement ACLA Provider Handbook, page123.	Full	This requirement is addressed in Specialty Care Provider Agreement, pages 4(2) and 6 (4.8). While the specific language of the requirement is not found in the referenced material, there is evidence that the intent of the regulation is included. Examples are provided in the excerpts below. Excerpts: "Provider agrees to provide Specialty Care Services to Members in accordance with the terms of this agreement and ACL	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				referral, preauthorization and other Utilization Management Program Policies…", "Provider shall provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement…", and "Provider shall accept as patients those Members who have selected or been referred to Provider without regard to the health status or medical condition of such Members."	
7.8.2	**Primary Care Provider Responsibilities**				
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:				
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17.	
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17.	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17.	
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17-19.	
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 17.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 20.	
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	159.201 Provider Accessibility Standards and Compliance Policy	Full	The requirement is addressed in Provider Handbook, page 22.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Provider Manual	Full	The requirement is addressed in CP 210.104 Credentialing-Recredentialing of Practitioners, page 3.	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 19.	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 19.	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 19	
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.				
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in Network Development Plan (20160504), page 24; and in BH GEO Access Report 2016 Q3.	
7.8.3.3	The MCO shall ensure access to appropriate	159.202 Provider	Full	The requirement is addressed in	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	Geographical Access Policy		Network Development Plan (20160504), page 24.	
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	159.202 Provider Geographical Access Policy PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	The requirement is addressed through the provider Geographical Access Policy and the MCO's GeoAccess reports.	
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in 159.202 Provider Geographical Access Policy-BH updated.pdf, page 3.	
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 24.	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.				
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital.	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in Network Development Plan (20160504), page 24.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	MCO must establish access to the following within their network of hospitals: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.				
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	159.202 Provider Geographical Access Policy	Full	The requirement is addressed in Network Development Plan (20160504), page 24.	
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	159.701 Single Case Agreement Workflow	Full	The requirement is addressed in Network Development Plan (20160504), page 24.	
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	
7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 25.	
7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 25.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.				
7.8.6.2	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.	Member Handbook	Full	The requirement is addressed in the Member Handbook, pp 22; and in Network Development Plan (20160504), page 25.	
7.8.6.4	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 25.	
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14)	124.01.010L Assigning Primary Care Physicians and changing Primary Care Physicians	Full	The requirement is addressed in Network Development Plan (20160504), pages 25-24; in Member Handbook, page 24; and in 124.12.010 Assigning Primary Care Physicians and Changing Primary Care Physicians, page 3. There is no evidence that the 14 day	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	calendar days after birth to select a PCP prior to assigning one.			timeframe is communicated to members. MCO Post-Onsite Response: The MCO's Bright Start team assists the member with selecting a PCP for the baby; however, there is no requirement to notify the member that a PCP will be assigned if not selected within 14 days of birth. Recommendation: Although not a requirement, the MCO should make every effort to provide members with information that impacts PCP selection. The MCO should update the Member Handbook to reflect the14 day timeframe.	
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.				
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the	Network Development Plan	Full	The requirement is addressed in Network Development Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).			(20160504), page 26.	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall work with the existing network of behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	Network Development Plan	Full	The requirement is addressed in ACLA Behavioral Management Network Development & Management Plan (20151116), page 8.	
7.8.14.4	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing required peer services (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or CPST).	Network Development Plan	Full	This requirement is addressed in ACLA Behavioral Health Network Development & Management Plan (20151116), pages 17, 22-23, 24, and 32.	
7.8.14.5	The MCO shall ensure that within the provider network, members enrolled in Home and Community Based waiver services have a choice of behavioral health providers, which	Network Development Plan	Full	The requirement is addressed in Network Development Plan, page 27.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.				
7.8.14.7	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. The community- based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management and intervention, mobile crisis teams, and crisis stabilization in an alternative settings. If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.	Network Development Plan	Full	The requirement is addressed in ACLA Behavioral Management Network Development & Management Plan (20151116), pages 20-22.	
7.8.14.9	The MCO shall require behavioral health providers to screen for basic medical issues, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.	ACLA Website Screenshot-BH Medical Screening Form BH Medical Screening Form	Full	The requirement is addressed in Provider Handbook, page 33.	
7.9	**Network Provider Development Management Plan**				
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504).	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.206):				
7.9.1.1	Anticipated maximum number of Medicaid members;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 17.	
7.891.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 17.	
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 17.	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 17.	
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 17.	
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Network Development Plan	Full	MCO achieved full determinations for sub sections to this requirement. (See below.)	
7.9.2.1	Assurance of Adequate Capacity and Services	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 22-32.	
7.9.2.2	Access to Primary Care Providers	Network Development Plan	Full	The requirement is addressed in Network Development Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				(20160504), pages 22 and 29.	
7.9.2.3	Access to Specialists	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 24.	
7.9.2.4	Access to Hospitals	Network Development plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 24-25.	
7.9.2.5	Access to Behavioral Health Services	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 10-12; and ACLA Behavioral Health Network Development & Management Plan (20151116).	
7.9.2.67	Timely Access	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 31.	
7.9.2.7	Service Area	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 30.	
7.9.2.8	Other Access Requirements: Direct Access to Women's Health, Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 25-26, and 28-30.	
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 8-11.	
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.	PH GeoAccess Report 2016 Q3 BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in Network Development Plan (20160504), page 30; in PH GeoAccess Report 2016 Q3; and in BH GeoAccess Report 2016 Q3.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 16-17.	
7.9.5.2	Monitor network compliance with policies and rules of DHH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	159.201 Provider Accessibility Standards and Compliance	Full	The requirement is addressed in Network Development Plan (20160504), page 16.	
7.9.5.3	Evaluate the quality of services delivered by the network;	159.201 Provider Accessibility Standards and Compliance	Full	The requirement is addressed in Network Development Plan (20160504).	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 7-8.	
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	159.201 Provider Accessibility Standards and Compliance	Substantial	This requirement is partially addressed in 159.201 Provider Accessibility standards and Compliance Policy – BH update, page 5. However, it does not explicitly address monitoring adequacy, accessibility and availability related issues faced by members with limited proficiency in English. Recommendation: The policy should be updated to include the missing standard.	
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 17-18, and 35-36.	
7.9.5.7	Provide training for its providers and maintain records of such training;	Provider Manual	Full	The MCO provided screenshots of MACESS, an internal application for tracking training.	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information	Network Development Plan	Full	The requirement is addressed in Network Development Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and take systemic action as necessary and appropriate;			(20160504), page 36.	
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 36.	
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 4-13.	
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.	Network Development Plan Network Development Plan Cove Sheet	Full	This requirement is addressed in ACLA Behavioral Health Network Development & Management Plan (20151116); Network Development Plan (20160504); and ACLA Annual Network Management Plan FTP Upload Screenshot.	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Network Development Plan	Full	The requirement is addressed in ACLA Behavioral Health Network Development & Management Plan (20151116); and Network Development Plan (20160504). .	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	BH GeoAccess Report 2016 Q3	Full	This requirement is addressed in Network Development Plan (20160504), and ACLA Behavioral Health Network Development & Management Plan (20151116).	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				The plans do not contain separate sections for each specialized behavioral health provider type for all covered services. However, the ACLA Behavioral Health Network Development & Management Plan (20151116) does contain the numbers and types (level of care) of in-state-Louisiana specialized behavioral health providers by region, pages 17-19; and the report also discusses treatment of adults and children in separate sections, pages 20-24. The Network Development Plan (20160504) contains the number of specialized BH providers by adult and children, page 33.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Network Development Plan	Full	The requirement is addressed in Network Development Plan, page 18.	
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network Development Plan	Full	This requirement is addressed in ACLA Behavioral Health Network Development & Management Plan (20151116), pages 17-19, and 33.	
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH	BH GeoAccess Report 2016 Q3	Full	The requirement is addressed in BH Geo Access Report 2016 Q3.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	quarterly by contract year, upon material change of the network, or upon request;				

	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:
	  • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
	  • Specialized behavioral health service needs of members; and
	  • Growth trends in eligibility and enrollment, including:
	  o Current and anticipated numbers of Title XIX and Title XXI eligibles; and
	  o Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.
		Network Development Plan	Full	This requirement is addressed in Network Development Plan (20160504), pages 10-15.	

	• Accessibility of services, including:
	  o The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible;
	  o The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation;
	  o Availability of specialized behavioral health services and appointments
		BH GeoAccess Report 2016 Q3	Full	This requirement is addressed in Network Development Plan (20160504), ACLA Behavioral Health Network Development & Management Plan (20151116), and BH GeoAccess Report 2016 Q3.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.				
7.9.8.3	The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.	Network Development Plan	Full	This requirement is addressed in Network Development Plan (20160504), and ACLA Behavioral Health Network Development & Management Plan (20151116).	
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract;	Network Development Plan	Full	This requirement is addressed in Network Development Plan (20160504), and ACLA Behavioral Health Network Development & Management Plan (20151116).	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.				
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: • Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.	Network Development Plan	Full	This requirement is addressed in Network Development Plan (20160504), and ACLA Behavioral Health Network Development & Management Plan (20151116).	
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs,	Network Development Plan	Substantial	The requirement is partially addressed in addressed in Network Development Plan (20160504), pages 17 and 28. The referenced material does not include language regarding annual	ACLA will include the frequency and duration of training into future network development plans and all related policies.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.			cultural competency trainings of at least 3 hours for MCO staff and BH network providers. Recommendation: The MCO should include the frequency and duration of training into future network development plans and related policy and procedures. In response to the draft report, the MCO will update related policy to include training requirements. The review determination remains as "substantial".	
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), pages 4-11.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.				
7.11	**Material Change to Provider Network**				
7.11.1	The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 21; and in 159.301 Provider Termination Process, page 6.	
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services,	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, page 7.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	payments, or eligibility of a new population.				
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, page 7.	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, pages 7-8.	
7.11.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite the approval process.				
7.11.6	The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, pages 6-7.	
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, page 1.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	exempt from this requirement.				
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by DHH.	Network Development Plan	Full	The requirement is addressed in 159.301 Provider Termination Process, page 7.	
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	Network Development Plan	Full	The requirement is addressed in 159.301 Provider Termination Process, page 7.	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:	159.301 Provider Termination Process	Full	The requirement is addressed in 159.301 Provider Termination Process, page 7-8.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.				
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.	Network Development Plan	Full	The requirement is addressed in 159.301 Provider Termination Process, page 8.	
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	UM.706L Continuity of Care	Full	The requirement is addressed in 159.301 Provider Termination Process, page 8.	
7.12	**Coordination with Other Service Providers**				
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start	Network Development Plan	Full	The requirement is addressed in Network Development Plan (20160504), page 26.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).				
7.13	**Provider Subcontract Requirements**				
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 102.	
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**				
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	CP 210.104 – Credentialing – Recredentialing of Practitioners	Full	The requirement is addressed n CP 210.104 – Credentialing-Recredentialing of Practiioners.pdf, and CR.100.LA (2015) Practitioner Credentialing and Recredentialing.pdf. MCO submitted an excerpt from BH Readiness Review, dated 2015 Q4 as evidence of submission of procedures to LDH within sixty (60) calendar days. The MCO was found to be fully compliant by LDH according to this excerpt.	
7.14.1.1	Prior to subcontracting, the MCO shall follow DHH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full	CP 210.101 – Organizational Provider Certification Policy	Full	The requirement is addressed in CP 210.101 Organizational Provider Certification Policy, pages 2 and 10.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	accreditation within eighteen (18) months following the initial contracting date with: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).				
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	7.14.2 – LA-Organizational Provider Application 7.14.2 – LA-Practitioner Application 7.14.2 – Blank CAQH Application	Full	The requirement is addressed in 7.14.2 LA Organizational Provider Application; in 7.14.2 LA Practitioner Application; and in 7.14.2 Blank CAQH Application.	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	CP 210.101 – Organizational Provider Certification Policy	Full	The requirement is addressed in CP 210.101 Organizational Provider Certification Policy, pp 1; and in CP 210.104 Credentialing Recredentialing of Practitioners, page 2.	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	7.14.4 – Summary Results NCQA	Full	The requirement is addressed in 7.14.4 Summary Results NCQA. MCO Onsite Comment: This is the most current document.	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	CP 210.104 – Credentialing – Recredentialing of Practitioners	Full	The requirement is addressed in CP 210.104 Credentialing Recredentialing of Practitioners, page 4. File Review Results: Of the five (5) credentialing files reviewed onsite, all five (5) files include evidence of timely credentialing, including evidence of all necessary documentation.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	Provider Data Integrity Analyst workflow	Full	The requirement is addressed in Provider Data Integrity Analyst Workflow. Recommendation: This requirement should be organized in an official policy and procedure.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.14.5.2	Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or	ACLA Provider Directory & ACLA Provider Directory-BH Example-Provider Registry outbound file (text file)	Full	The requirement is addressed in Example Provider Registry Outbound File.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	CP 210.103 – Provider Denial Termination and Appeal Process	Full	The requirement is addressed in CP 210.103 Provider Denial Termination and Appeal Process, page 3; and 159.301 Provider Termination Process.pdf, pages 3 and 6.	
7.14..6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements.	VSP Contract Part 1	Full	The requirement is addressed in VSP Contract Part 1, page D-11.	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.	N/A-- ACLA does not use delegated credentialing agencies. All provider credentialing is completed by ACLA.	N/A	The MCO does not use delegated credentialing agencies	
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	N/A-- ACLA does not use delegated credentialing agencies. All provider credentialing is completed by ACLA.	N/A	The MCO does not use delegated credentialing agencies	
7.14.9	The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	7.14.9 – DHH Denials Terms Sample Report	Full	The requirement is addressed in 7.14.9 DHH Denials Terms Sample Report. Recommendation: The requirement should be organized in an official policy and procedure.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	CP 210.101 – Organizational Provider Certification Policy	Full	The requirement is addressed in CP 210.104 Credentialing-Recredentialing of Practitioners,	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		CP 210.104 – Credentialing-Recredentialing of Practitioners		page 2. File Review Results: Of the five (5) recredentialing files reviewed onsite, all five (5) files include evidence of timely recredentialing.	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	CP 210.104 – Credentialing-Recredentialing of Practitioners	Full	The requirement is addressed in CP 210.104 Credentialing Recredentialing of Practitioners.	
7.14.12	The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	CP 210.104 – Credentialing-Recredentialing of Practitioners	Full	The requirement is addressed in 159.301 Provider Termination Process.pdf, page 6.	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	CP 210.103 – Provider Denial Termination and Appeal Process	Full	The requirement is addressed in CP 210.103 – Provider Denial Termination and Appeal Process. pdf.	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.				
7.16	**Provider-Member Communication Anti-Gag Clause**				
7.16.1	Subject to the limitations in 42 CFR	Provider Manual	Full	The requirement is addressed in	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	§438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:			Provider Handbook, page 102.	
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 102.	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 102.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 102.	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Member Handbook	Full	The requirement is addressed in Provider Handbook, page 102; and in Member Handbook, page 40.	
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.				
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Provider Manual	Full	The requirement is addressed in Provider Handbook, page 102.	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
8.1	**General Requirements**				
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	UM.003L Standard and Urgent Prior Authorization	Full	UM.003L Standard and Urgent Prior Authorization Policy Pg. 1-8 addresses this element. Confirmation/evidence of submission to DHH was requested onsite and the MCO stated that DHH never sends confirmation emails.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:				
8.1.2.1	Are adopted in consultation with contracting health care professionals;	UM.008L Clinical Criteria	Full	The P/P UM.008L Clinical Criteria Policy (pg. 1) meets this requirement.	
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	UM.008L Clinical Criteria	Full	The P/P UM.008L Clinical Criteria Policy (pg. 1) meets this requirement.	
8.1.2.3	Are considerate of the needs of the members; and	UM.008L Clinical Criteria	Full	The P/P UM.008L Clinical Criteria Procedure #3, (pgs. 3-4) meets this requirement.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	UM.008L Clinical Criteria pg. 1	Full	The P/P UM.008L Clinical Criteria Policy (pg. 1) meets this requirement.	
8.1.3	The policies and procedures shall include, but not be limited to:				
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	UM 003L Standard and Urgent Prior Authorization UM.002L Concurrent Review UM.008L Clinical Criteria	Full	The P/P UM 003L (pgs. 3-5) addresses this element for services requiring prior authorization, UM 002L (p. 3) addresses this element for hospital services; UM 008L (pgs. 1-2) meets requirement.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	UM.008L Clinical Criteria	Full	The P/P UM.008L Clinical Criteria Policy, (pg. 1) meets the requirement.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Pre-onsite: UM 003L Standard and Urgent Prior Authorization Post-onsite:	Full	The P/P UM 003L Standard and Urgent Prior Authorization 3rd Paragraph, (pg. 2) meets this element for prior authorization only. The deficiency (requirement language should be added to	ACLA will amend the policy to include the required language.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				UM.008L Clinical Criteria Policy) was discussed with the MCO onsite which submitted the P/P UM.002L Concurrent Review Policy, (Page 2), 1st paragraph in response; this P/P meets the element for concurrent review. Recommendation: The MCO should add the requirement language to P/P UM.008L Clinical Criteria Policy.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	UM.010L Timeliness of UM Decisions, pg. 5 UM.105L Peer to Peer Discussion, pgs. 2-4	Full	The P/P UM.010L Timeliness of UM Decisions, pg. 5 addresses this element. The P/P UM.105L Peer to Peer Discussion, pgs. 2-4 meets this requirement.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	UM.008L Clinical Criteria UM.708L Inter-Rater Reliability	Full	The P/P UM.008L Clinical Criteria, pgs. 1-2 addresses this element. The P/P UM.708L Inter-Rater Reliability Procedure, (pgs. 2-3) meets the requirement	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	Pre-onsite: UM 003L Standard and Urgent Prior Authorization pg. 3 Post-onsite: P/PUM.002L Concurrent Review Policy, Policy section, page 2, 1st paragraph * CCMP Predictive Modeling, entire document. CCMP Predictive Modeling Specifications	Full	The P/P UM 003L Standard and Urgent Prior Authorization (pg. 3) addresses prior authorizations only. This issue was discussed onsite with the MCO which provided the following response: P/PUM.002L Concurrent Review Policy, Policy section, page 2, 1st paragraph, and CCMP Predictive Modeling, entire document; CCMP The P/P CCMP Predictive Modeling Specifications were submitted for other elements and meets this requirement.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	UM.008L Clinical Criteria, pg. 2	Full	The P/P UM.008L Clinical Criteria, (pg. 2) meets this requirement.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	UM.008L Clinical Criteria, pg. 1	Not Met	The contract language is not found in submitted P/P UM.008L Clinical Criteria (pg. 1). The deficiency was discussed with the MCO onsite.	ACLA will amend the UM policies to include the required language.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The required language should be incorporated in to a P/P for UM or P/P Coordination of services. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "not met."	
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	156.800 Care Transition - Discharge Planning	Full	The P/P 156.800 Care Transition - Discharge Planning (pg. 2) meets this requirement.	
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	156.800 Care Transition - Discharge Planning	Full	The submitted policy, 156.800 Care Transition - Discharge Planning (pg.2) meets requirement.	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	156.800 Care Transition - Discharge Planning	Full	The submitted policy, 156.800 Care Transition - Discharge Planning (pg.2) meets requirement.	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	156.800 Care Transition - Discharge Planning	Full	The submitted policy, 156.800 Care Transition - Discharge Planning (pg.2) meets requirement.	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting	Pre-onsite: 2016 QAPI Program Description	Full	The 2016 QAPI Program Description, (pg. 35) lists CPGs, but the contract language requirement	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	practice guidelines from different MCOs.	Post-onsite: CPG Policy and adoption CPG screenshot from ACLA website QCCC Committee minutes Letter showing Collaboration among Plans		is not found in this document. This issue was discussed onsite with the MCO which stated that LDH has only implemented this requirement for certain CPGs (e.g., ADHD and LARC) and submitted the following to meet the requirement: CPG Policy and adoption (addresses element) CPG screenshot from ACLA website (not provided for review, however a link to the provider portal to access CPGs was found on MCO website) QCCC Committee minutes (addresses element) Letter showing Collaboration among Plans (addresses element for LARC).	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Pre-onsite: UM.008L Clinical Criteria Post-onsite: CPG Policy and adoption CPG screenshot from ACLA website (not provided for review) Letter showing Collaboration among Plans	Full	The Provider Handbook, (pg. 33) states CPGs are available on the MCO website and addresses the requirement. The P/P for UM UM.008L Clinical Criteria Procedure #5 does not address this element. The issue was discussed with the MCO onsite which submitted the following, which meets the requirement: CPG Policy and adoption 205. 700 (pg. 2), CPG screenshot from ACLA website (not provided for review, however, a link to the provider portal to access CPGs including BH CPGs for ADHD, SA, Schizophrenia, and Major Depressive Disorder	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				were found on the MCO website), Letter showing collaboration among Plans.	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	2016 QAPI Program Description Treatment Record Review Documentation Standards	Full	The QAPI Program Description, (pgs. 16 and 39-40) addresses this element. The Treatment Record Review Documentation Standards addresses element. Neither provider contracts, nor compliance reports were submitted for review to provide evidence of 80% compliance. The issue was discussed onsite with the MCO which submitted the following response: ACLA provided documentation and evidence of this previously. However, the state has advised of a two-year implementation period in which to make a report.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	Pre-onsite: 2016 QAPI Program Description Post-onsite: UM.008L Clinical Criteria Policy, Policy section, pages 1-2	Full	The 2016 QAPI Program Description, (pg. 35) lists the sources for CPGs; a P/P for medical management criteria was not submitted for review. The issue was discussed onsite with the MCO which submitted the P/P UM.008L Clinical Criteria Policy, Policy section, (pgs. 1-2) which meets the requirement.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	2016 QAPI Program Description	Full	The 2016 QAPI Program Description, (pg. 35) lists the sources for CPGs; a P/P for medical management criteria was not submitted for review. The issue was discussed onsite with the MCO which submitted the P/P UM.008L Clinical Criteria Policy,	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Policy section, (pgs. 1-2) which meets the requirement.	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	2016 QAPI Program Description	Full	The 2016 QAPI Program Description, (pg. 35) lists the sources for CPGs; a P/P for medical management criteria was not submitted for review. The issue was discussed onsite with the MCO which submitted the P/P UM.008L Clinical Criteria Policy, Policy section, (pgs. 1-2) which meets the requirement.	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	2016 QAPI Program Description	Full	The 2016 QAPI Program Description, (pg. 35) lists the sources for CPGs; a P/P for medical management criteria was not submitted for review. The issue was discussed onsite with the MCO which submitted the P/P UM.008L Clinical Criteria Policy, Policy section, (pgs. 1-2) which meets the requirement.	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	UM 003L Standard and Urgent Prior Authorization	Full	The P/P UM 003L Standard and Urgent Prior Authorization, (pg. 2) meets the requirement.	
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Pre-onsite: UM.008L Clinical Criteria Post-onsite: CPG Policy and adoption CPG screenshot from ACLA website (not submitted but found on MCO website as above) Provider Handbook, page 121	Full	The P/P for UM UM.008L Clinical Criteria, Procedure 5 pg. 4 does not address this element. A P/P for guideline dissemination was not submitted for review. This issue was discussed onsite with the MCO which submitted the following documents meeting this element: CPG Policy and adoption CPG screenshot from ACLA website (not submitted but found on MCO	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				website as above) Provider Handbook, page 121	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	Pre-onsite UM 003L Standard and Urgent Prior Authorization Post-onsite: UM.008L Clinical Criteria; page 4 #2 , and #5 to meet below they said onsite	Full	The P/P UM 003L Standard and Urgent Prior Authorization Procedures 7-8, (pg. 4) has contract language for information required, but not for dissemination. The issue was discussed onsite with the MCO which responded with the following documents meeting the requirement: UM.008L Clinical Criteria Provider Handbook, Authorization Requirements, pages 43 – 80 UM Program Description 2016, Authorizations section, Page 4	
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	UM 003L Standard and Urgent Prior Authorization	Full	The P/P UM 003L Standard and Urgent Prior Authorization Procedures 7-8, (pg. 4) contains contract language meeting the requirement.	
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: Specialized behavioral health services, and PSH to ensure appropriate authorization of tenancy services.	Pre-onsite: UM Program Description 2015	Full	The UM Program Description 2015, Section: Utilization Management Staff pg. 8 has FTEs noted. It may be clearer to show per service authorization or per case, as well as provide evidence of staff clinical expertise, e.g., licensure or credentials. No P/P for UM was submitted for review. The issues were discussed onsite with the MCO which submitted the following documents meeting the requirement: ACLA BH UM Org Chart UM organizational chart	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Clinical Care Reviewer UM	
8.1.11	The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	UM.008L Clinical Criteria; pg. 3	Full	The P/P UM.008L Clinical Criteria Definitions, (pg.3) states the MCO uses the LDH contract, which meets the requirement.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	Pre-onsite: UM 003L Standard and Urgent Prior Authorization Post-onsite: UM organizational chart Clinical Care Reviewer UM	Full	The P/P UM 003L Standard and Urgent Prior Authorization, (Pg. 2) states any denials will be approved by the medical director or MD. A staffing plan was not submitted for review. In response to discussing this issue onsite, the MCO submitted the following which meet the requirement: UM organizational chart Clinical Care Reviewer UM	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Pre-onsite: UM 003L Standard and Urgent Prior Authorization pg. 5	Full	The P/P UM 003L Standard and Urgent Prior Authorization, (pg. 2) does not meet language requirement. In response to discussing this issue onsite the MCO submitted the following which meet the requirement: Medical Director (Behavioral Health), Medical Director, Clinical Care Reviewer UM; and ACLA Appeals Policy, page 6, #3.	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	Pre-onsite: UM 003L Standard and Urgent Prior Authorization UM.002L Concurrent Review Post-onsite: UM.002L Concurrent Review Policy Medical Director (Behavioral Health)	Full	The P/P UM 003L Standard and Urgent Prior Authorization, (pg. 1) addresses this requirement for BH and PSH, and states the ACLA Medical Director or physician designee (pg. 2) shall make the determination. The P/P UM.002L Concurrent Review, (pg. 1) does not address	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Medical Director ACLA Appeals Policy, page 6, #3		element. The issue of whether denials are determined by professionals with appropriate clinical expertise in the member's condition or disease was discussed onsite with the MCO which stated a General Practitioner makes determinations, with the option (rather than the requirement) to consult a specialist as stated in the policy. The Medical Director/physician designee may consult a specialty Practitioner/Provider for input into the determination. Post onsite the MCO submitted the following which address this element: UM.002L Concurrent Review Policy Medical Director (Behavioral Health) Medical Director ACLA Appeals Policy, page 6, #3. <u>File Review Results</u>: Five of the ten UM denial files reviewed onsite required clinical expertise and all five files were compliant for this element.	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	UM Program Description 2015	Full	The UM Program Description 2015, (pgs. 16-17) addresses language for medical director and designees (not approved/signed/dated). A P/P for UM was not submitted. This issue was discussed onsite during which the MCO stated that they don't sign or date the UM Program Description and that they would send the meeting minutes for when the UM PD was approved.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Post-onsite the MCO submitted the P/P UM Program Description 2016, Medical Necessity Decision Making section, (page 15), 2nd paragraph which addresses the element, but is not signed, or dated. The submitted QCCC meeting minutes (June 7, 2016) provide evidence of approval of the 2015 UM Program Evaluation (in which the element language was not found).	
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	Utilization Management Statement	Full	The Utilization Management Statement is not a policy, and is undated/unsigned; it does not contain element language. This issue was discussed with the MCO onsite and the MCO submitted the P/P UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, paragraphs 3-5, which states: the ACLA Medical Director and the physicians supporting the Medical Director sign a statement upon hire indicating that no adverse determination will be made regarding any medical procedure or service outside the scope of the individuals' expertise.	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of	Pre-onsite: UM.003L Standard and Urgent Prior Authorization UM.002L Concurrent Review UM Program Description 2015 Post-onsite: UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, 1st	Substantial	The P/P UM 003L Standard and Urgent Prior Authorization, Procedure #10, 11 does not contain the contract language, The P/P UM.002L Concurrent Review (pg. 5 4) Procedure #7 does not contain contract language either. The UM Program Description 2015,	ACLA will amend its UM policies to include the required language.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	paragraph;		(pgs. 4-5) contains some but not all of contract language. This issue was discussed onsite with the MCO which submitted P/P UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, 1st paragraph which includes the element language except for stating that EPSDT services may not be limited based on medical necessity or for the purpose of utilization control. Recommendation: The MCO should add contract language related to EPSDT to a UM P/P. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	Utilization Management Statement	Full	A P/P for UM was not submitted for this element. The Utilization Management Statement is not a policy, and is undated/unsigned but does contain element language. This issue was discussed with the MCO onsite which stated that they would provide an actual attestation signature. Post-onsite the MCO submitted UM Program Description 2016, Medical Necessity Decision Making section, page 16, 4th paragraph which addresses this element.	
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent	UM.003L Standard and Urgent Prior Authorization	Full	The P/P UM.003L Standard and Urgent Prior Authorization;	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization and post authorization.	UM.002L Concurrent Review		addresses prior authorizations only, and the P/P UM.002L Concurrent Review addresses concurrent hospital authorizations only. No P/P addressing post authorizations (other than ER) was submitted for review. In response to discussing this issue with the MCO onsite, they submitted the P/P UM.200L Post-Service Review Policy which meets the requirement.	
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert and Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:	UM156.401 UM PA Workflow for Managing PA Requests UM Program Description 2015 pg. 4-5	Substantial	The UM156.401 UM PA Workflow for Managing PA Requests addresses this element. The UM Program Description 2015 (pg. 4-5) is not signed or dated; the final page "Approval" is blank. As noted above, the MCO stated onsite that QCCC meeting minutes would be provided to show approval of the UMPD, but the UM Evaluation rather than UMPD was approved during this meeting. Recommendation: The MCO should incorporate the requirement into a P/P for UM or P/P for service authorization. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	ACLA will amend its UM policies to include the required language.
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	UM Program Description 2015	Full	The UM Program Description 2015, (pg. 4) is not a policy; it is not signed or dated. In response to discussing this issue onsite the MCO submitted the following: ACLA is currently following this process as documented in the UM	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Program Description.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	UM.708L Inter-Rater Reliability	Full	The P/P UM.708L Inter-Rater Reliability addresses this element; however evidence of application was not submitted and was requested onsite. In response, the MCO submitted the P/P UM.002L Concurrent Review Policy which does not provide evidence of implementation. Post-onsite, the MCO submitted ACLA 2016 UM Program Evaluation_addendum_051316 (2) (2), (pgs 9-11) which was approved during the submitted QCCC meeting minutes (6-7-16) and meets this requirement.	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	UM.003L Standard and Urgent Prior Authorization UM.002L Concurrent Review	Full	The P/PUM.003L Standard and Urgent Prior Authorization, Procedure #11, (pg. 5) does not contain contract language for appropriate clinical expertise. The P/P UM.002L Concurrent Review, Procedure #7, pg. 4 does not contain contract language for appropriate clinical expertise. In response to the onsite discussion of this issue, the MCO submitted the UM Program Description 2016, Medical Necessity Decision Making section, page 15, 2nd paragraph; page 16, paragraphs 3-5, which address this element	
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	UM.003L Standard and Urgent Prior Authorization	Substantial	The UM.003L Standard and Urgent Prior Authorization, Procedure #1, (pg. 3) addresses this element, but does not address incorporation into grievance procedures. The member Handbook (pg. 33)	Melissa: Not sure why we would do this. I thought all service auth requests had to come from a provider.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				addresses this element. Onsite the MCO submitted P/P UM Program Description 2016, Authorizations section, page 15, 2nd paragraph; page 16, paragraphs 3-5 which does not address grievance procedure incorporation. A review of the Member Grievances Policy and Procedure (pg. 3) define service authorizations as an "action" and explicitly excludes them from the Grievance procedures. Recommendation: The MCO should clarify its policy and ensure that service authorization requests are included in grievance procedures. In response to the draft report, the MCO did not submit additional evidence or commit to addressing the recommendation. The determination remains as "substantial."	
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	UM.003L Standard and Urgent Prior Authorization UM.002L Concurrent Review	Full	The P/P UM.003L Standard and Urgent Prior Authorization Policy— 2nd paragraph and Last paragraph, pg. 2 contains contract language and meets requirement. UM.002L Concurrent Review Policy- 2nd and Last paragraph, pg. 2 does not contain contract language.	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	UM.003L Standard and Urgent Prior Authorization. 2 second paragraph UM.002L Concurrent Review, pg. has capacity language in first full paragraph	Full	The P/P UM.003L Standard and Urgent Prior Authorization Policy— 2nd paragraph and Last paragraph, (pg. 2) and The P/P UM.002L Concurrent Review Policy- 2nd and Last paragraph, (pg. 2) meet this requirement.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	UM.017L Notice of Adverse Determination, pg 2	Full	The requirement is met in UM.017L Notice of Adverse Determination, (pg 2).	
8.4.4	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	UM.003L Standard and Urgent Prior Authorization, pg. 1 UM.002L Concurrent Review, pg. 1 and 3 UM.904L Authorization for Out-of-Network Practitioners and Providers, pg 2	Full	The P/P UM.003L Standard and Urgent Prior Authorization, (pg. 10) has prior authorization language for hospitals and psychiatric facilities, and all out-of –network providers. It does not specifically state: specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals. The MCO clarified onsite that their out-of-network policy covers all out-of-state facilities and that there a no State mental hospitals in LA, meeting the requirement. The P/P UM.002L Concurrent Review, (pg. 1 and 3) addresses inpatient hospital language; the P/P UM.904L Authorization for Out-of-Network Practitioners and Providers, (pg. 20) addresses out-of-network.	
8.4.4.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	2015 UM Program Description, pg. 16	Substantial	The 2015 UM Program Description, (pg. 16) is in draft (tracked changes) form, and is unsigned. It states that: Medical Necessity decisions made by the ACLA Medical Director or designee are based on the Department of Health and Hospital's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the Member's benefits, medical expertise, ACLA Medical Necessity guidelines (as	ACLA will clarify this responsibility and also incorporate it into a P&P.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				outlined in Policy UM.008L: *Clinical Criteria*), DHH contract, the Louisiana Behavioral Health Partnership (LBHP) Services Definition Manual and/or published peer-review literature. At the discretion of the ACLA Medical Director/designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting Practitioner/Provider may provide input to the decision. The ACLA Medical Director or designee makes the final decision. The MCO stated onsite that all denials are made by a General Practitioner, and post-onsite, provided QCCCI meeting minutes as evidence of QAPI Committee approval of the 2015 UM PD, which was not found in the minutes. Recommendation: The MCO should clarify whether LMHPs conduct reviews or only conducts them at the discretion of a general practitioner Medical Director. The MCO should revise policies if necessary, or submit existing policies to meet this requirement. In response to the draft report, the MCO will clarify and update policies. The review determination remains as "substantial."	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These	Pre-onsite: N/A – ACLA submits encounter data per Molina	Substantial	A P/P for UM was not submitted for this element. After discussing this issue onsite the MCO submitted the	ACLA will amend its UM policies to include the requested language.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	specifications. Concurrent utilization reviews are not a reportable field on the encounter layout Post-onsite: UM.002L Concurrent Review Policy		P/P UM.002L Concurrent Review Policy in which the following contract language was not found: "However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment. " Recommendation: The MCO should include the missing contract language in the P/P. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	
8.4.4.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in	UM Program Description 2015, pgs. 5-7 UM.010L Timeliness of UM Decisions, pg.2	Full	The 2015 UM Program Description, pgs. 5-7 is in draft form and does not contain the contract language. The P/P UM.010L Timeliness of UM Decisions, (pg.2) only contains the contract language related to timeliness of emergency and urgent psychiatric screens. The MCO stated onsite that they do not incorporate the full requirement language into a policy, and post-onsite provided the PQ188 report which provides evidence of implementation, but not of timely submission. File Review Results: Three of the ten UM files reviewed onsite involved an inpatient Psychiatric Hospitalization concurrent UR and all 3 files were compliant for timeliness, with notification of right to appeal.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately,			Recommendation: The MCO may want to consider including the contract language in a policy. File review did provide evidence of implementation of the timeliness policy.	

Utilization Management					
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	and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.				
8.4.4.4	Certification of Need for PRTFs				
8.4.4.4.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.				
8.4.4.4.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	UM.004L PRTF Authorization Process, Procedure Section 3(a)(5) pg. 2	Full	The requirement is met in UM.004L PRTF Authorization Process.	
8.4.4.4.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	UM.004L PRTF Authorization Process Procedure Section 3(a)(5), pg. 2	Full	The requirement is met in UM.004L PRTF Authorization Process.	
8.4.4.4.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	UM.004L PRTF Authorization Process Procedure Section 7(a), pg. 3	Full	The requirement is met in UM.004L PRTF Authorization Process.	
8.4.4.4.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. • Ensure that PRTF certification, including the independent certification, are	UM.004L PRTF Authorization Process Procedure: Sections 6 and 7, pgs. 3-4 UM Program Description 2015, pgs. 5-7 UM.010L Timeliness of UM Decisions, pg. 2	Substantial	Tracking reports were not submitted for review. The UM Program Description 2015, (pgs. 5-7) only contains 48 hour timeline for PRTF approval notification, but not include immediate notification for denials.	ACLA will develop a tracking report and a P&P regarding timely notification to the provider.

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	forwarded to the admitting facility. • Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal, and the process to do so. • Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. • Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. • Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. • Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.			The MCO provided QCCC meeting minutes as evidence of acceptance of the 2015 UM PD post-onsite, in which approval of the UMPD was not found. UM.010L Timeliness of UM Decisions, (pg. 2) does not contain language about notifying the provider within 48 hours. After discussing the issues onsite, the MCO stated they don't give the provider notice, although they do FAX the dates of service approved. The MCO submitted a BH UM PRTF Denial Letter Example, and BH UM Approval Member Letter Example. Recommendation: The MCO should develop a Tracking report and a P/P that includes policy regarding timely notification to the provider. In response to the draft report, the MCO will develop a tracking report and policy. The review determination remains as "substantial."	
8.4.5	At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.	N/A – TFC is not an ACLA benefit.	N/A	No documentation was submitted for review. When the issue was discussed onsite with the MCO, they stated it is not a benefit provided by ACLA and that they stated they would confirm that it's an excluded benefit in their contract.	
8.5	**Timing of Service Authorization Decisions**				
8.5.1	**Standard Service Authorization**				
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization	Pre-onsite: UM.010L Timeliness of UM	Full	The P/P UM.010L Timeliness of UM Decisions lists the timeframes in	ACLA will amend its UM policy to include the required

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	Decisions, pgs.1-3 Post-onsite: UM Operational Review Report ACLA 2016 UM Program Evaluation_addendum_051316 (2) (2)		which authorizations and notices must take place, but not the requirement that the MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days. After discussing the issue onsite with the MCO, they provided the UM Operational Report which captures the timeframes denoting compliance/non-compliance as reported to the state as evidence of implementation, but does not meet policy requirements. Post-onsite: The ACLA 2016 UM Program Evaluation_addendum_051316 (2) (2) was found, and meets the requirement on pg. 6. File Review Results: All UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO should incorporate the requirement language "shall make eighty percent (80%) of standard service authorization determinations within two (2) business days" into a P/P for UM or P/P for standard service authorization.	language.
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	Pre-onsite: UM.010L Timeliness of UM Decisions, pgs.1-3 Post-onsite: UM Operational Review Report	Full	The P/P UM.010L Timeliness of UM Decisions lists the timeframes in which authorizations and notices must take place, but not the requirement that the MCO shall make ninety-five percent (95%) of concurrent review determinations	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		ACLA 2016 UM Program Evaluation_addendum_051316 (2) (2)		within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required. After discussing the issue onsite with the MCO, they provided the UM Operational Report which captures the timeframes denoting compliance/non-compliance as reported to the state as evidence of implementation, but not the policy requirement. Post-onsite, the ACLA 2016 UM Program Evaluation_addendum_051316 (2) (2) was found, and meets the requirement on pg. 6. File Review Results: All UM denial/adverse action files reviewed onsite were compliant for timeliness.	
8.5.2	**Expedited Service Authorization**				
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	Pre-onsite: UM.010L Timeliness of UM Decisions Pg 2/5 Post-onsite: UM Operational Report	Full	The requirement is met in the P/PUM.010L Timeliness of UM Decisions (pg. 2/5) and evidence of implementation was provided post-onsite in the UM Operational Review Report. File Review Results: All ten UM denial/adverse action files reviewed onsite were compliant for timeliness and for notification of the circumstances under which expedited resolution is available and how to request it.	
8.5.2.2	The MCO may extend the seventy-two (72)	UM.010L Timeliness of UM	Full	The requirement is met in the	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.	Decisions Pg. 5 #3		P/PUM.010L Timeliness of UM Decisions (pg. 5) and evidence of implementation was provided post-onsite in the UM Operational Review Report. File Review Results: None of the UM denial/adverse action files reviewed onsite involved an extension.	
8.5.3	**Post Authorization**				
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Pre-onsite: UM.010L Timeliness of UM Decisions Pg 2 Post-onsite: UM.200L Post Service Review	Full	The P/P UM.200L Post Service Review (pg.1) meets the requirement. File Review Results: All UM denial/adverse action files reviewed onsite were compliant for timeliness.	
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Pre-onsite: Emergency Room Services, pg. 2 Post-onsite: UM Program Description 2016, Medical Necessity Decision Making section, page 16, paragraph 1	Full	The requirement is addressed the UM Program Description 2016, Medical Necessity Decision Making section, (pg. 16), paragraph 1.	
8.5.4	**Timing of Notice**				
8.5.4.1	**Notice of Action**				
8.5.4.1.1	**Approval [Notice of Action]**				
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	UM.010L Timeliness of UM Decisions, pg. 2	Full	The requirement is met in the P/P UM.010L Timeliness of UM Decisions, (pg. 2).	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO	UM.010L Timeliness of UM Decisions, pg. 2 to 3, "service	Full	The requirement is met in UM.010L Timeliness of UM Decisions, (pgs. 2	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	determination" is being used as meeting all services (not specifically extended stay or additional services" onsite		to 3). The language of the policy was discussed onsite with the MCO, which provided clarification to meet the requirement and additionally provided the *UM Operational Report.	
8.5..4.1.2	**Adverse [Notice of Action]**				
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	UM.017L Notice of Adverse Determination, pg. 1	Full	The requirement is met in the P/P UM.017L Notice of Adverse Determination, (pg. 1). File Review Results: All ten UM denial/adverse action files reviewed onsite were compliant for providing the reason for the denial in a manner and format that is easily understood, and provided notice of the member's or provider's right to file an HMO or PIHP appeal as well as how to file the appeal. Three of the ten reviewed files involved a member's right to request a State fair hearing after the HMO/PIHP's appeal process had been exhausted, and all three files were compliant in providing information on how to make the request.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial	UM.017L Notice of Adverse Determination, pg. 1	Full	The requirement is met in the P/PUM.017L Notice of Adverse Determination, (pg. 1). File Review Results: All ten UM denial/adverse action files reviewed onsite were compliant for timeliness.	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.				
8.5.4.1.3	**Informal Reconsideration**				
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	UM.105L Peer to Peer Discussion, pg. 2	Full	The requirement is met in UM.105L Peer to Peer Discussion, pg. 2. After discussing whether there is an informal process for members as well as for providers acting on their behalf, the MCO stated the regulation does not require a process for members, and that 'there is no requirement that the language of the policy follow verbatim the language of the contract, as long as the policy captures the spirit and intent of the contract. Also, peer-to-peer is another name for informal reconsideration. Therefore, we are resubmitting the referenced policy." This explanation was accepted as meeting the requirement. File Review Results: Six of the ten UM denial/adverse action files reviewed onsite involved reconsiderations and all 6 files were compliant.	
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	UM.105L Peer to Peer Discussion, pg. 1 UM.002L Concurrent Review Procedure #9, pg. 4	Full	The requirement is met in the P/Ps UM.105L Peer to Peer Discussion, (pg. 1) and UM.002L Concurrent Review Procedure #9, (pg. 4). After discussing whether there is an informal process for members as well as for providers acting on their behalf, the MCO stated the regulation does not require a process for members, and that 'there is no requirement that the language of the policy follow verbatim the language of the	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				contract, as long as the policy captures the spirit and intent of the contract. Also, peer-to-peer is another name for informal reconsideration. Therefore, we are resubmitting the referenced policy." This explanation was accepted as meeting the requirement File Review Results: Six (6) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all 6 files were compliant.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	UM.105L Peer to Peer Discussion Procedure #4, pgs. 2-3	Full	The requirement is met in UM.105L Peer to Peer Discussion Procedure #4, pgs. 2-3. File Review Results: Five (5) of the five (5) information reconsideration files reviewed onsite included evidence of the MCOs attempts to ensure a timely peer-to-peer was conducted. In cases where the cycle went beyond (1) working day, it was due to the requesting provider's unavailability to conduct the peer-to-peer. The MCO maintained excellent documentation of all attempts made to reach the requesting providers.	
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	UM.105L Peer to Peer Discussion Procedure #7, pg. 3	Full	The requirement is met in UM.105L Peer to Peer Discussion Procedure #7, (pg. 3). File Review Results: Six of the ten UM denial/adverse action files reviewed onsite involved reconsiderations and all 6 files were compliant for timeliness.	
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-	UM.003L Standard and Urgent Prior Authorization	Full	The requirement is met in UM.003L Standard and Urgent Prior	

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	stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	Attachment A, pg. 8		Authorization Attachment A, (pg. 8).	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Substantial	The P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8) states authorization is required for newborn deliveries exceeding 48 hours (vaginal) and 96 hours (c-section). The MCO stated onsite that their policy mirrors CMS language that after 48 hours a delivery is not "normal." Recommendation: The MCO's policy should be consistent with LDH regulations. In response to the draft report, the MCO will update policies to ensure consistency with LDH regulations. The review determination remains as "substantial."	ACLA will clarify its policy to ensure consistency with LDH regulations.
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The requirement is met in UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8).	
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	UM.706L Continuity of Care, pgs. 1-2	Full	The requirement is met in UM.706L Continuity of Care, (pgs. 1-2).	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	UM.904L Authorization for Out-of-Network Practitioners and Providers, pg. 1	Full	The requirement is met in UM.904L Authorization for Out-of-Network Practitioners and Providers, (pg. 1).	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The requirement is met in the P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8).	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	preventive women's healthcare services and prenatal care.				
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The requirement is met in the P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8).	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The requirement is met in the P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8).	
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8) states "Authorization Required "vs. allowed "notification." T This issue was discussed onsite with the MCO which responded that they don't' consider obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section to be a "normal" delivery as noted above, and that the regulation allows them to require authorization for stays.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	UM.003L Standard and Urgent Prior Authorization Attachment A, pg. 8	Full	The P/P UM.003L Standard and Urgent Prior Authorization Attachment A, (pg. 8) states all inpatient stays require authorization vs. notification. The issue was discussed onsite with the MCO which stated that they are allowed to require authorization.	
8.11	**Medical History Information**				
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.	Pre-onsite UM.002L Concurrent Review Procedure #1, pg. 3 Post-onsite: UM.003L Standard and Urgent Review	Full	The P/P UM.002L Concurrent Review Procedure #1, (pg. 3) addresses the requirement for inpatient stays. The P/P UM.003L Standard and Urgent Review meets the requirement.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical	UM.003L Standard and Urgent Prior Authorization, Procedure #8	Full	The requirement is met in the Provider Manual, in the Ancillary Service Agreement,	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	history information within the requested timeframe.	pg. 4 Ancillary Service Agreement, pg. 6-7		Quality Management/Utilization Management #4.6, (pp .6-7), and in UM.003L Standard and Urgent Prior Authorization, Procedure #8 (pg. 4).	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Ancillary Service Agreement, pg. 6-7 Manual/Handbook, pg. 53	Full	The requirement is met in the Provider Manual and in the Ancillary Service Agreement, Quality Management/Utilization Management #4.6, (pp .6-7).	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	Ancillary Service Agreement, pg. 6-7	Full	The requirement is met in the Provider Manual and in the Ancillary Service Agreement, Quality Management/Utilization Management #4.6, (pp .6-7).	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**				
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	2016 QAPI Program Description14 (bullet # 9)	Substantial	PCP/BN profiling reports were not submitted for review. The contract language is not stated in 2016 QAPI Program Description (pg. 14, bullet # 9). This issue was discussed onsite with the MCO which in response submitted the LA HEDIS Summary, HEDIS IDSS, and Provider Performance Report. The Provider Performance Report is redacted, and does not provide evidence of profiling of specialized behavioral health providers (ADHD medication is the only BH measure). The HEDIS IDSS reports several BH measures (including SMD, SMC, AMM, SSD, AMM, but does not report FUH), and does not provide individual provider results. The only BH measure found in the LA HEDIS summary is ADD.	ACLA has already begun developing this profile/report, which will be in place by Q2 2017.

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				It doesn't appear that any of the BH measures are used to profile providers. Recommendation: The MCO should develop profile reports of its specialized BH providers. In response to the draft report, the MCO has stated that it has have already initiated the development of the profile report. The review determination remains as "substantial."	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	2016 QAPI Program Description, pg. 13	Full	The 2016 QAPI Program Description, (pg. 13), and the QCCC Committee meeting minutes FINAL 6 7 16 (which provides evidence of implementation) meet this requirement.	
8.12.3	The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall include, but are not limited to, the following:	N\A – This report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH.	N/A	No documentation was submitted for review. In response to the onsite inquiry the MCO provided the statement: This report was deactivated well before the review period. Therefore, ACLA has no report to submit for this item.	This information was previously captured in the 072 report. That report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH. Since then, LDH has not required or provided a template to capture such.
8.12.3.1	Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	UM.904L Authorizations for Out-of-Network Practitioners and Providers Procedure #3, pg. 3	Not Met	The contract language was not found in the P/P UM.904L Authorizations for Out-of-Network Practitioners and Providers, (pg. 3). The MCO did not provide a response for this deficiency discussed onsite. Follow-up is required. Recommendation: The MCO should develop a mechanism to identify and evaluate member utilization of out of network providers.	This information was previously captured in the 072 report. That report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH. Since then, LDH has not required or provided a template to capture such. It should also be noted that referrals are not required for a member to access care from a provider other than his/her PCP. It should also be noted that referrals are not required for a

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				In response to the draft report, the MCO states that referrals are not required for a member to access care from a provider other than his/her PCP, however, the response does not address the identification and evaluation of member out-of-network provider referral utilization by in-network PCPs. The determination remains as "not met."	member to access care from a provider other than his/her PCP.
8.12.3.2	Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	UM.904L Authorizations for Out-of-Network Practitioners and Providers, pg. 1	N/A	The contract language was not found in the P/P UM.904L Authorizations for Out-of-Network Practitioners and Providers, (pg. 1). The MCO has not yet provided a response for this deficiency discussed onsite. Follow-up is required. Recommendation: The MCO should provide the necessary documentation. In response to the draft report, the MCO states that referrals are not required for a member to access care from a provider other than his/her PCP. The determination has been changed to "N/A."	This information was previously captured in the 072 report. That report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH. Since then, LDH has not required or provided a template to capture such. It should also be noted that referrals are not required for a member to access care from a provider other than his/her PCP.
8.12.3.3	Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;	UM.905L Emergency Room Services Pg2/3.	N/A	The contract language was not found in the P/P UM.905L Emergency Room Services (pgs.2/3). The MCO has not yet provided a response for this deficiency, which was discussed onsite. Follow-up is required. Recommendation: The MCO should provide the necessary documentation. In response to the draft report, the MCO states that referrals are not	This information was previously captured in the 072 report. That report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH. Since then, LDH has not required or provided a template to capture such. It should also be noted that referrals are not required for a member to access care from a provider other than his/her PCP.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				required for a member to access care from a provider other than his/her PCP. The determination has been changed to "N/A."	
8.12.3.4	Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	2016 QAPI Program Description, pg 11	Full	The 2016 QAPI Program Description, (pg. 11) addresses this element without noting the specific services in the regulation. A P/P for lab, hospital utilization, radiology and medication was not submitted for review. In response to the onsite inquiry, the MCO submitted the Provider Performance Report which does address Hospital admits, lab services, medications, and radiology services.	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	NIA AmeriHealth Annual Program Review Section: Top 20 Ordering Physicians, pgs. 16-18 Section: Hospital Provider Detail, pg. 25 Section: AmeriHealth LA Provider Variation, pg. 3	Full	The NIA AmeriHealth Annual Program Review summarizes Imaging utilization. In response to the onsite inquiry the MCO stated that Appendix J was retired.	
8.13	**PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements**				
8.13.0	The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	N\A – This report was active from Feb. 2012 to Jan. 2015, at which time it was retired by LDH.	N/A	No documents were submitted for review. The MCO responded to the onsite inquiry with this statement: This report was deactivated well before the review period. Therefore, ACLA has no report to submit for this item.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11	**Disenrollment**				
11.11.1	Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the Bayou Health Program.				
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	124.12.001—Disenrollment and Enrollment Transition; Definitions: Disenrollment, page 3.	Full	The requirement is stated verbatim on page 3 of 124.12.001.	
11.11.3	**Member Initiated Disenrollment**				
11.11.3.1	A member may request disenrollment from a MCO as follows: For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member requests to be assigned to the same MCO as family members; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and DHH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; • The member's active specialized behavioral health provider ceases to contract with the MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by	124.12.001—Disenrollment and Enrollment Transition; Policy, 2nd paragraph, page 2.	Full	The requirement is stated verbatim on page 2 of 124.12.001.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	DHH and/or its agent.				
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).	124.12.001—Disenrollment and Enrollment Transition; Policy, 3rd paragraph, page 2.	Full	The requirement is stated verbatim on page 2 of 124.12.001.	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	124.12.001—Disenrollment and Enrollment Transition; Procedure for Member-Initiated Disenrollment, #2 and #3, page 4.	Full	Policy 124.12.001 states that if members call the Health Plan requesting disenrollment, Member Services will instruct the member that disenrollment requests must go to the Enrollment Broker and will initiate a warm transfer. The Policy also states that written requests will be sent to the Enrollment broker. All disenrollment requests are documented by the Plan.	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	124.12.001—Disenrollment and Enrollment Transition; Procedure for Member-Initiated Disenrollment, #4, page 4.	Full	The requirement is stated verbatim on page 4 of 124.12.001.	
11.11.4	**MCO Initiated Disenrollment**				
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from his or her special needs, unless	124.12.001—Disenrollment and Enrollment Transition; Policy, 2nd paragraph, page 1.	Full	The requirement is stated verbatim on page 1 of 124.12.001.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).				
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.	124.12.001—Disenrollment and Enrollment Transition; Policy, pages 1-2.	Full	Policy 124.12.001 states on page 2 "ACLA shall not request disenrollment for reasons other than what is outlined above."	
11.11.4.3	The following is the only allowable reason for which the MCO may request involuntary disenrollment of a member: the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH;	124.12.001—Disenrollment and Enrollment Transition; Policy, 3rd paragraph, page 1.	Full	The Policy & Procedure for Disenrollment and Enrollment Transition states on page 1 "ACLA has the right to initiate disenrollment of a member only if: 1. The member misuses or loans the member's ID card to another person to obtain services." Additionally, the Policy states that the ACLA Director of Compliance & Regulatory Affairs will be notified, and then will submit a DHH referral.	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	124.12.001—Disenrollment and Enrollment Transition; Policy, 4th paragraph, page 2.	Full	The requirement is stated verbatim on page 2 of 124.12.001.	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member**	124.12.001—Disenrollment and Enrollment Transition; Procedure for Plan-Initiated Disenrollment #3, page 4.	Full	The requirement is stated verbatim on page 4 of 124.12.001.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Disenrollment form (See Appendix T).				
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	124.12.001—Disenrollment and Enrollment Transition; Procedure for Plan-Initiated Disenrollment #4, page 4.	Full	The requirement is stated verbatim on page 4 of 124.12.001.	
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	124.12.001—Disenrollment and Enrollment Transition; Procedure for Plan-Initiated Disenrollment #5, page 4.	Full	The requirement is stated verbatim on page 4 of 124.12.001.	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.				
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	124.12.001—Disenrollment and Enrollment Transition; Procedure for Plan-Initiated Disenrollment #7, page 4.	Full	The requirement is stated verbatim on page 4 of 124.12.001.	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**				
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):				
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: Flesch – Kincaid; Fry Readability Index; PROSE The Readability Analyst (software developed by Educational Activities, Inc.); Gunning FOG Index; McLaughlin SMOG Index; or other computer generated readability indices accepted by DHH.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, pages 2-3.	
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 2.	
12.9.3	DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 2-4.	
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 3.	
12.9.5	All written materials must be in accordance with the DHH “Person First” Policy, Appendix NN.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 3.	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO’s commercial plans if applicable.	N/A (ACFC does not have commercial plans)	N/A	The MCO does not have a commercial plan operating in Louisiana.	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 3.	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, pp 2.	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 3.	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 2.	
12.11	**Member Education – Required Materials and Services**				
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 2.	
12.11.3	**Member Materials and Programs for Current Enrollees**				
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	ACLA Member Home Page: https://www.amerihealthcaritasla.com/member/eng/index.aspx ACLA Member Portal: http://www.amerihealthcaritasla.com/member/eng/tools/member-portal.aspx	Full	Screenshots of member portal received.	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	ACLA Member Newsletter (Summer 2016) ACLA Member Newsletter (Winter 2015)	Full	The requirement is addressed in ACLA Member Newsletters, Summer 2015, Winter 2015 and Summer 2016. MCO Onsite Comment: Member	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Newsletter is produced quarterly.	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	ACLA Bi-Fold EPSDT Reminders	Full	The requirement is addressed in ACLA Bi-Fold EPSDT Reminders; and in ACLA Feeling Great Checklist.	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	ACLA Diabetes Knowledge Is Power Brochure	Full	The requirement is addressed in ACLA Diabetes Knowledge is Power Brochure; in ACLA Feeling Great Checklist; and in http://www.amerihealthcaritasla.com/member/eng/benefits/special-programs.aspx.	
12.11.3.5	Materials focused on health promotion programs available to the members;	ACLA IHCM Brochure	Full	The requirement is addressed in ACLA IHCM Brochure, and in http://www.amerihealthcaritasla.com/member/eng/benefits/special-programs.aspx.	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	ACLA How to Prep for your Doctor Visit Brochure	Full	The requirement is addressed in ACLA How to Prep for your Doctor Visit Brochure; and in Member Handbook, page 41.	
12.11.3.7	Materials that promote the availability of health education classes for members;	ACLA Bi-Fold On The Move Brochure	Full	The requirement is addressed in ACLA Bi-Fold On The Move Brochure. MCO Onsite Comment: This information is available on the website and also provided at member events.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	ACLA Tri-Fold Get Your Flu Shot	Full	The requirement is addressed in ACLA Tri-Fold Get Your Flu Shot; and in http://www.amerihealthcaritasla.com/preventive-care/member/index.aspx.	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	ACLA Feeling Great Checklist	Full	The requirement is addressed in ACLA Feeling Great Checklist; Connections Volume II 2016.	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.11.3.11	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 40.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	ACLA 205.100 (Member Materials)	Full	The requirement is addressed in ACLA 205.100, page 4.	
12.12	**MCO Member Handbook**				
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (f)(6) for each of the covered populations as specified in section 3.3.3.)..	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook for the Medicaid population.	
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:				
12.12.1.2	Table of contents;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 1.	
12.12.1.3	A general description about how MCOs operate, member rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 2, and 10-13.	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 38.	
12.12.1.5	Member's right to change providers within the MCO;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 48.	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pp 48-49.	
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 39-41.	
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 8-22.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 31-33.	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 7.	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 22 and 33.	
12.12.1.12	The extent to which, and how, after-hours , crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.	ACLA Member Handbook	Full	The requirement is partially addressed in ACLA Member Handbook, pages 8, 13, 21, 23 and 31. The Member Handbook instructs the member to seek care at the "nearest ER." It does not include the "the locations of any emergency settings and other locations at which providers and hospital furnish emergency services and post-stabilization services covered by the MCO." Recommendation: Update Member Handbook to include locations of emergency settings and other locations at which providers and hospital furnish emergency services and post-stabilization services covered by the MCO. The MCOs response to the draft report clarified its compliance with the requirement. The review determination has been changed to "full."	The handbook is correct to direct members to the nearest ER, as this encompasses the "location of any emergency settings…at which providers…furnish emergency and post-stabilization services." Because emergency and post-stabilization services are covered at any ER across the country, regardless of the hospital's participating status with the plan, it is not feasible to list every ER nationwide in the member handbook. Furthermore, this same language was found fully compliant in the previous 2015 IPRO readiness review of this provision. For these reasons, we request reconsideration of this determination.
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 8.	
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 32. MCO Onsite Comment: We do not require referrals for specialists	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				including BH specialists.	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 35.	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	ACLA Member Handbook	Substantial	The requirement is partially addressed in ACLA Member Handbook, page 40. Language regarding "religious grounds" is not found in the Member Handbook. MCO Onsite Comment: There are non-discriminatory clauses throughout the Member Handbook. However, the clauses do not specifically state "religious grounds." Recommendation: Include explicit language in Member Handbook regarding right to refuse medical services due to religious reasons. In response to the draft report, the MCO will update the member handbook to include the refusal of treatment for religious beliefs. The review determination remains as "substantial."	The member has the right to refuse treatment for any reason, which includes religious grounds. Furthermore, this same language was found fully compliant in the previous 2015 IPRO readiness review of this provision. Per your recommendation, we will add this clarification to the next revision of our handbook; however, we request reconsideration of this determination as the current language includes religious grounds although not explicitly stated.
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 8.	
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 44-46.	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: the right to a hearing; the method for obtaining a hearing; and the rules that govern	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, pages 44-46.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing a grievance or appeal; • The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.				
12.12.1.20	Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 43; and in ACFC 124 12 035 (Advance Directives).	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	given.				
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 41.	
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 12. MCO Onsite Comment: During welcome call member is educated on "showing up" for appointments.	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	ACLA Member Handbook	Full	The requirement is partially addressed in ACLA Member Handbook. The MCO's email and fax number are missing from the Member Handbook. MCO Onsite Comment: The fax number is available and if a member calls the MCO, the member can get the fax number. Members can go to the website to send electronic communication – this is noted in the Member Handbook. Recommendation: Include MCO's email address, or instructions on how to communicate electronically with MCO, and the MCO's fax number in the Member Handbook.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 16.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 26.	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 37.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	ACLA Member Handbook	Full	The requirement is partially addressed in ACLA Member Handbook, page 37. Language regarding employer sponsored insurance is missing from the Member Handbook. MCO Onsite Comment: During the welcome call the member is asked to report other forms of insurance. Recommendation: Include explicit language in Member Handbook regarding member responsibility of reporting employer sponsored insurance to the MCO and/or LDH.	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 41.	
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, Back Cover.	
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 15.	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 47.	
12.12.1.32	Any additional text provided to the MCO by DHH or deemed essential by the MCO;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, Back Cover.	
12.12.1.33	The date of the last revision;	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, revision date August 2016.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.6(h)]. Service utilization policies; and How to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 39.	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: • A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers; • General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; • Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and • Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.	ACLA Member Handbook	Full	This requirement is addressed in ACLA Member Handbook, pages 19, 22, 27 and 42. MCO Onsite Comment: The language has been modified to adjust for member understanding.	
12.12.1.36	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	ACLA Member Handbook	Full	The requirement is addressed in ACLA Member Handbook, page 39.	
12.12.1.37	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members.	ACLA Member Handbook	Full	Last Member Handbook was published May 2016. The MCO submitted evidence of DHH approval for Member Handbook published May 2016. Current Member Handbook was published August 2016. Recommendation:	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				The MCO should have a policy and procedure documenting this requirement.	
12.14	**Provider Directory for Members**				
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	ACLA 170.104 (Provider Directory	Full	See determinations for 12.14.1.1, 12.14.1.2, 12.14.1.3, and 12.14.1.4.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	ACLA 170.104 (Provider Directory	Full	The requirement is addressed in ACLA 170.104, page 3; and in ACLA 2016 Provider Directory.	
12.14.1.2	Web-based, searchable, online directory for members and the public;	ACLA 170.104 (Provider Directory	Full	The requirement is addressed in ACLA 170.104, page 3; and in http://amerihealthcaritasla.prismisp.com/?brandcode=ACLA	
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and	ACLA 170.104 (Provider Directory	Full	The requirement is addressed in ACLA 170.104, page 3; and Sample Electronic Provider Directory Submission. MCO Onsite Comment: File is called Provider Registry. The document is submitted to the Fiscal Intermediary, the FI submits to Maximus.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	ACLA 170.104 (Provider Directory	Full	The requirement is addressed in ACLA 170.104, page 3; and in ACLA Abbreviated Provider Directory. pdf.	
12.14.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by	ACLA 170.104 (Provider Directory	Full	The requirement is addressed in ACLA 170.104, page 3-4.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	DHH.				
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:				
12.14.4.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;	ACLA Provider Directory	Full	The requirement is addressed in ACLA 2016 Provider Directory; and in https://www.amerihealthcaritasla.com/member/eng/index.aspx	
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	ACLA Provider Directory	Full	The requirement is addressed in ACLA 2016 Provider Directory. Youth Residential Services and Home and Community Based Services are reported under other headings. MCO Post-Onsite Comment: Youth Residential Services are included in Psychiatric Residential Treatment Facilities on pages 662 – 663. There is not a separate listing, because there is no LDH-defined Youth Residential Service provider type. YRS is a subset of PRTF. Similarly, Home & Community-Based Services do not have a distinct LDH provider type, as this encompasses several different provider types, such as Behavioral Health Rehab Agencies (page 626 of ACLA Provider Directory) and Community Mental Health Centers (page 639 of ACLA Provider Directory). Therefore, there is no heading for HCBS. A person needing this information would look for the specific HCBS needed, such as a Behavioral Health Rehab Agency.	
12.14.4.3	Identification of any restrictions on the	ACLA Provider Directory	Full	The requirement is addressed in	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	enrollee's freedom of choice among network providers; and			2016 Provider Directory, provider panel status.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	ACLA Provider Directory	Full	The requirement is addressed in 2016 Provider Directory; and in ACLA 170.104, pages 2-3.	
12.17.15	**Members' Rights and Responsibilities**				
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	ACLA 124.12.019 (Member Rights & Responsibilities)	Substantial	The requirement is partially addressed in ACLA 124.12.019; in Member Handbook, pages 39-41; in Provider Handbook, Section X: Member Rights & Responsibilities; and Logisticare Contract. While the contract includes explicit language about PHI and general language that refers to member rights and responsibilities, e.g., timely rides, clean vehicles, etc., the contract does not state that a copy of the official member rights and responsibilities are shared with Logisticare. MCO Onsite Comment: Member Rights and Responsibilities are available to Member Services staff via an online help tool; they also have access to Member Rights and Responsibilities. MCO associates use the Policy in their everyday work. <u>Recommendation</u>: MCO should share Member Rights and Responsibilities with all vendors and subcontractor who provide direct services to members. In response to the draft report, the MCO will distribute Member Rights and Responsibilities to subcontractors who work directly with members. The review	ACLA will distribute the Member Rights and Responsibilities to subcontractors who work directly with members.

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				determination remains as "substantial."	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	ACLA 124.12.019 (Member Rights & Responsibilities)	N/A		
12.17.16	**Member Responsibilities**				
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	ACLA 124.12.019 (Member Rights & Responsibilities)	Full	The requirement is addressed in ACLA 124.12.019; in Member Handbook, page 41; and in Provider Handbook, Section X: Member Rights & Responsibilities.	
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement	ACLA 124.12.019 (Member Rights & Responsibilities)	Full	The requirement is addressed in ACLA 124.12.019; in Member Handbook, page 41; and in Provider Handbook, Section X: Member Rights & Responsibilities.	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.				
12.18	**Notice to Members of Provider Termination**				
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	ACLA 124.12.018 (Notice to Members of Provider Termination)	Full	The requirement is addressed in ACLA 124.12.018, page 2.	
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	ACLA 124.12.018 (Notice to Members of Provider Termination)	Full	The requirement is addressed in ACLA 124.12.018, page 2.	
12.19	**Oral and Written Interpretation Services**				
12.19.1	In accordance with 42 CFR §438.10(b)(1) DHH shall provide on its website the prevalent non-English language spoken by enrollees in the state.				
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and	ACLA 124.12.020 (Services for Members with LEP, LLP and Sensory Impairment)	Full	The requirement is addressed in ACLA 124.12.020, page 10; in ACLA 205.100, page 3; in Member	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.			Handbook, pages 5, 40, 55, and the Back Cover.	
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	ACLA 124.12.020 (Services for Members with LEP, LLP and Sensory Impairment)	Full	The requirement is addressed in ACLA 124.12.020, page 11.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**				
13.2	**General Grievance System Requirements**				
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted.	Member Grievances Policy and Procedure, pg. 3 Med. Mgmt. Appeals Policy and Procedure, pg. 1-2	Full	A P/P for Fair Hearing was not submitted for review although the requirement language is included in the Appeals Policy and in the Grievance Policy.	
13.2.2	**Filing Requirements**				
13.2.2.1	**Authority to File**				
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	Member Grievances Policy and Procedure, pg. 4 2. Med. Mgmt. Appeals Policy and Procedure, pg. 4	Full	The requirement is met in the submitted P/Ps.	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	Member Grievances Policy and Procedure #2 Med. Mgmt. Appeals Policy and Procedure, pg. 4	Full	The Med. Mgmt. Appeals Policy and Procedure, pg. 4 does not contain element language for State Fair Hearings. The Appeal Policy meets language requirement.	
13.2.3	**Time Limits for Filing** The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	Member Grievances Policy and Procedure, pg. 4 Med. Mgmt. Appeals Policy and Procedure, pg. 4	Full	The requirement is met in the submitted documents.	
13.2.4 13.2.4.1	**Procedures for Filing** The member or provider may file an appeal either orally or in writing.	Pre-onsite: Member Grievances Policy and Procedure, pg. 4 Med. Mgmt. Appeals Policy and Procedure, pg. 4. Post-onsite: Member Handbook (Page 44; Member Grievances, Appeals and Fair Hearing) Provider Handbook (PDF Page 140; Member Grievance and Appeal Process)	Full	The requirement is not stated in The Appeals Policy. After discussing the deficiency on-site, the MCO submitted the following: Member Handbook (Page 44; Member Grievances, Appeals and Fair Hearing); and Provider Handbook (PDF Page 140; Member Grievance and Appeal Process) Recommendation: The element language should be	ACLA will address in a policy.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				included in a P/P so that MCO staff is aware of how to implement the contract.	
13.2.4.2	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	Pre-onsite: Grievance and Appeal Webpage, pg. 1 Member Handbook.pdf, pg. 46. Post-onsite: P/P 124.12.004—New member Education and Communication (Pages 2-3; Welcome Packet)	Full	The element language to provide each member with a handbook is not included in Grievance or Appeals Policies; forms language is stated in Appeals Policy. The Member Handbook pg. 46 does not contain required forms language. After discussing the issues onsite, the MCO submitted P/P 124.12.004—New member Education and Communication (Pages 2-3; Welcome Packet) which meets the requirement.	
13.3					
13.3.1	The MCO must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	Member Grievances Policy and Procedure. Pg. 7 Med. Mgmt. Appeals Policy and Procedure, pg. 2	Full	The element is met in the submitted Grievance and Appeals P/Ps.	
13.3.2	The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	Member Grievances Policy and Procedure. Pg. 7 Med. Mgmt. Appeals Policy and Procedure, pg. 2	Full	The element is addressed in Member Grievances Policy and Procedure. pg. 7, and in Med. Mgmt. Appeals Policy and Procedure, pg. 2. The 112 ACLA 2016 05 (Member Grievance) was found in the QM MCO post-onsite resubmission for the month of May 2016, as was the Louisiana Monthly Appeals Report May 2016 which indicates 6 of 10	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				DME appeals were overturned, 4 of 4 home health services appeals were overturned, and 10 of 25 pharmacy appeals were overturned. The MCO Analysis states that Hepatitis C appeals continue to account for the majority of pharmacy appeals. The MCO provided a screen shot dated June 15, 2016 as evidence of submission to LDH.	
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	Member Grievances Policy and Procedure. Pg. 6 Med. Mgmt. Appeals Policy and Procedure, pg. 2	Full	The requirement is met in the submitted P/Ps: Member Grievances Policy and Procedure (pg. 6) and in Med. Mgmt. Appeals Policy and Procedure (pg. 2).	
13.4	**Handling of Grievances and Appeals**				
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:				
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	Member Grievances Policy and Procedure, pg. 5 Med. Mgmt. Appeals Policy and Procedure. Pg. 6	Full	The Grievance Policy does not contain the element language: "Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log." Template letters were not submitted for review. After discussing the issue with the MCO onsite, the MCO stated on Crosswalk (13 - Member Grievance Appeal) that the following was submitted for this element (although it was not found uploaded to the IPRO FTP): 170.201 Member Grievances (Page 5; #5; Handling of Grievances) (Page 7; Grievance Records and Reports).	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				File Review Results: Of the ten (10) appeal files reviewed onsite, all ten (10) included evidence of timely acknowledgement in writing. Recommendation: The element was deemed "fully complaint" because file review indicated that timeliness standards were met. However, the MCO should incorporate the contract language in a policy or other document (e.g., P/P for Grievances, P/P for Appeals, Acknowledgement Letter Template) to meet this requirement.	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	Member Grievances Policy and Procedure, pg. 6 Med. Mgmt. Appeals Policy and Procedure. Pg. 4	Full	The requirement is met in the submitted policies. Recommendation: The element language" "Providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability" language should be added to the Member Handbook, Grievance and Appeal sections, as well as indicating all languages available for interpretation.	
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves	Med. Mgmt. Appeals Policy and Procedure, pg. 8	Full	The requirement is found in P/P Med. Mgmt. Appeals, (pg. 8); element language relative to grievances is not stated in Grievance Policy. File Review Results: For all fifteen (15) of the grievance files reviewed onsite, the reviewer was not involved in any previous level of review or decision-making. Four (4) of the fifteen (15) grievance	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	clinical issues.			files reviewed onsite involved clinical issues and all four (4) files had decisions determined by a clinician with appropriate clinical expertise.	
13.4.2	**Special Requirements for Appeals** The process for appeals must:				
13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.	Med. Mgmt. Appeals Policy and Procedure, pg.4	Full	The element is met in Med. Mgmt. Appeals Policy and Procedure, pg.4, and in the Member Handbook; no confirmation template letter was submitted for review.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Substantial	The requirement is addressed in Med. Mgmt. Appeals Policy and Procedure, pg. 6. The required language, "The MCO must inform the member of the limited time available for this in the case of expedited resolution is not found in the Member Handbook and the process for notifying members of opportunity to provide evidence was not submitted for review (no template letters provided). File Review Results: Of the ten (10) appeal files reviewed onsite, there was evidence in all ten (10) files that the member was informed of the right to provide evidence, allegations of fact or law, in person as well as in writing. Recommendation: The MCO should add the missing	ACLA will address by adding the required language to the member handbook.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				required language to the Member Handbook. In response to the draft report, the MCO will update the member handbook to include the required language. The review determination remains as "substantial."	
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	Med. Mgmt. Appeals Policy and Procedure, pg. 8	Minimal	The element is addressed in Med. Mgmt. Appeals Policy and Procedure, pg. 8 and in the Member Handbook. File Review Results: Of the ten (10) appeal files reviewed onsite, all ten (10) files were missing evidence that the member was informed of the right to request case files before the appeals process. Recommendation: The MCO should update the denial letter template to include language that informs members of the right to request case files and other related documents prior to initiating the appeal process. In response to the draft report, the MCO will update the denial template to include the required language. The review determination remains as "minimal."	ACLA is moving to update the denial template to include this language.
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	Med. Mgmt. Appeals Policy and Procedure, pg. 5	Full	The required language is included in the Appeals Policy, but is not found in the Member Handbook. File Review Results: Of the ten (10) appeal files reviewed onsite, all ten (10) files included evidence that the member and his/her representative were	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				included as parties to the appeal. Recommendation: The element was deemed "fully compliant" because file review indicated that all parties were included. However, language regarding this requirement should be added to the Member Handbook.	
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	(LOB 2100) New Hire Training Agenda Monthly Meeting Sign-In Sheet	Minimal	The LOB 2100 New Hire Training Agenda is undated, and is corporate-wide training in FL. Monthly Meeting Sign-In Sheets do not indicate that LA Plan staff was trained. This issue was discussed onsite and the MCO did not provide a response. Recommendation: The MCO should provide evidence of training LA staff to meet this requirement. In response to the draft report, the MCO submitted a PowerPoint Presentation that only provides a high-level grievance overview for a corporate-wide meeting. Training materials or evidence of training on member and provider rights was not submitted for review. The review determination remains as "minimal."	Evidence of grievance training: Please see slides 8-9 of the Town Hall PowerPoint. Evidence of appeals training: The previously submitted FL monthly meeting sign-in sheets capture associate participation and serve as documentation of ongoing appeals training. It should be noted that it is this Florida staff that handles all appeals on behalf of ACLA. Please know that ACLA is working on appeals and grievance refresher training that will be included in our next Town Hall presentation.
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Pre-onsite: Med. Mgmt. Appeals Policy and Procedure, pg 7 Post-onsite: Medical Director (Behavioral Health)_B4A002 Medical Director Medical Management	Full	The contract language was not found in Med. Mgmt. Appeals Policy and Procedure, pg. 7, and the name and title of individual or name of body having decision-making authority, or Job description for individual having decision-making authority was not submitted for review.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Organizational Chart. xlsx		In response to discussing this issue onsite, the MCO submitted the following statement: the language is found in the policy but is not exact contract language, as there is no requirement that the language be verbatim. See *Content of Notice* section, page 7. Post-onsite the MCO submitted the following documents for UM follow-up that meet the requirement: Medical Director (Behavioral Health)_B4A002 Medical Director Medical Management Organizational Chart. xlsx	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in §13.6 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	Med. Mgmt. Appeals Policy and Procedure, pg. 10	Full	It was discussed onsite that the element language:"as of the date upon which a final determination should have been made" should be added to the Appeals Policy. The MCO submitted the following response: The language is found in the policy but is not exact contract language, as there is no requirement that the language be verbatim. See *Member Appeals* section, page 10, #13, which was accepted as meeting this requirement.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	Med. Mgmt. Appeals Policy and Procedure, pg. 7	Full	The submitted Appeals Policy contains the element language. <u>File Review Results</u>: Of the ten (10) appeal files reviewed onsite, all ten (10) files included evidence that the member was informed of the right to seek a Fair Hearing.	
13.5	**Notice of Action**				

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and Section 12 of this RFP to ensure ease of understanding.	UM.017L Notice of Adverse Determination, pg. 3	Full	This requirement is met in UM.017L Notice of Adverse Determination, (pg. 3). File Review Results: All fifteen (15) grievance files reviewed onsite documented the date of the grievance, and provided notice in a manner and format that is easily understood.	
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:				
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	UM.017L Notice of Adverse Determination, pg. 3	Full	The element is addressed in UM.017L Notice of Adverse Determination, (pg. 3), which contains the contract language. File Review Results: All fifteen (15) grievance files reviewed onsite stated the results of the resolution process and the action the MCO intended to take.	
13.5.2.2	The reasons for the action;	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3). File Review Results: All fifteen (15) grievance files reviewed onsite documented the nature of the grievance as well as the investigation of the substance of the grievance, including any aspect of clinical care involved.	
13.5.2.3	The member's right to file an appeal with the MCO;	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3).	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3).	
13.5.2.5	The procedures for exercising the rights specified in this section;	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3).	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.5.2.6	The circumstances under which expedited resolution is available and how to request it;	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3).	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3). A Notice of Action template letter.	
13.5.2.8	Oral interpretation is available for all languages and how to access it.	UM.017L Notice of Adverse Determination, pg. 3	Full	The requirement language is included in UM.017L Notice of Adverse Determination, (pg. 3).	
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:				
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except:	UM.017L Notice of Adverse Determination, pg. 4	Full	The requirement language is met in UM.017L Notice of Adverse Determination, (pg. 4).	
13.5.3.1.1	The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following: • In the death of a recipient; • A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information); • The recipient's admission to an institution where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or • As otherwise permitted under 42 CFR §431.213.	Pre-onsite: UM.017L Notice of Adverse Determination, pg. 4 Post-onsite: Appeals policy. See *Timing of Notice*, page 6.	Full	The element language is not found in UM.017L Notice of Adverse Determination, (pg. 4). In response to discussing this issue onsite, the MCO submitted the appeals policy, See *Timing of Notice*, page 6, which contains the required language.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.5.3.2	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	UM.010L Timeliness of UM Decisions, pg. 1	Full	The element intent, if not exact language is addressed in UM.010L Timeliness of UM Decisions, pg. 1, in UM.017L Notice of Adverse Determination, and in Med. Mgmt. Appeals Policy and Procedure.	
13.5.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	UM.010L Timeliness of UM Decisions, pg. 5	Full	The requirement is addressed in UM.010L Timeliness of UM Decisions, pg. 5. File Review Results: None of the fifteen (15) grievance files reviewed onsite involved an extension.	
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Med. Mgmt. Appeals Policy and Procedure UM.010L Timeliness of UM Decisions	Substantial	The contract language relative to standard authorizations was not found in the submitted P/Ps. A template Notice of Decision to Extend Timeframe was not submitted for review. In response to discussing these issues onsite, the MCO submitted the following statement: The language is found in the attached appeals policy. See *Timing of Notice*, page 6. File Review Results: None of the fifteen (15) grievance files reviewed onsite involved an extension. Recommendation: The language in the submitted appeals policy (See *Timing of*	ACLA will ensure this language is incorporated into a UM policy.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Notice, page 6) refers to Appeals, not to standard authorizations as required for this element. A P/P for Notice of Action or P/P for Handling Extensions should be provided for compliance. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.5.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.	UM 003L Standard and Urgent Prior Authorization, Procedure #8 pg. 4	Substantial	The contract language relative to standard authorizations was not found in the submitted P/P. In response to discussing this deficiency onsite, the MCO submitted the following statement: The language is found in the attached appeals policy. See *Timing of Notice*, page 6. Recommendation: The language in the submitted appeals policy (See *Timing of Notice*, pg. 6) refers to Appeals, not to standard authorizations as required for this element. A P/P for Notice of Action should be provided for compliance. In response to the draft report, the MCO will update policies to include the required language. The review determination remains as "substantial."	ACLA will ensure this language is covered in a UM policy.
13.5.3.6	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization	UM.010L Timeliness of UM Decisions, pg. 1	Full	This requirement is met in UM.010L Timeliness of UM Decisions, (pg. 1).	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.				
13.5.3.7	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	UM.010L Timeliness of UM Decisions, Procedure #3 pg. 5	Full	The element language is found in UM.010L Timeliness of UM Decisions, Procedure #3 (pg. 5).	
13.5.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.				
13.6	**Resolution and Notification**				
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	Member Grievances Policy and Procedure, pg. 6 Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	This requirement is met in Member Grievances Policy and Procedure, (pg. 6), and in Med. Mgmt. Appeals Policy and Procedure, (pg. 6).	
13.6.1	**Specific Timeframes**				
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	Member Grievances Policy and Procedure, pg. 6	Full	The requirement is met in Member Grievances Policy and Procedure, (pg. 6), and Med. Mgmt. Appeals Policy and Procedure, (pg. 6).	
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, (pg. 6).	
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, (pg. 6).	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from	Pre-onsite: Member Grievances Policy	Full	The element language: "The MCO shows (to the satisfaction of DHH,	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	and Procedure, pg. 6 Med. Mgmt. Appeals Policy and Procedure, pg. 6 Post-onsite: UM010L Timeliness of UM Decisions, pg. 5		upon its request) that there is need for additional information and how the delay is in the member's interest" was not found in Appeals Policy. A Template Notice of Decision to Extend Timeframe was not submitted for review. In response to discussing this issue onsite, the MCO responded: The language is found in the ACLA Appeals policy but is not exact contract language, as there is no requirement that the language be verbatim. See Timing of Notice of Action section, page 6, #2. The P/P UM010L Timeliness of UM Decisions, pg. 5 was found submitted for UM follow-up and meets the required language. File Review Results: None of the 15 (15) grievance files reviewed onsite involved extensions.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	Member Grievances Policy and Procedure, pg. 6 Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	The contract language is stated in the submitted Appeals Policy. A Template Notice of Decision to Extend Timeframe not submitted for review. File Review Results: None of the fifteen (15) grievance files reviewed onsite involved extensions.	
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance.	Member Grievances Policy and Procedure, pg. 7 Med. Mgmt. Appeals Policy and Procedure, pg. 6 Member Handbook, pg. 45	Substantial	The contract language is stated in both submitted Grievance and Appeals Policies and in the Member handbook.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Appeals. For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.			File Review Results: Of the fifteen (15) grievance files reviewed onsite, thirteen (13) had evidence of an acknowledgment of receipt in writing within 5 days while two did not.	
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.	Med. Mgmt. Appeals Policy and Procedure, pg. 7	Full	The contract language is stated in the submitted Appeals Policy and in the Member Handbook except for "member being held liable In response to discussing this deficiency onsite, the MCO stated: The language is found in the ACLA Appeals policy but is not exact contract language, as there is no requirement that the language be verbatim. See Content of Notice section, page 7, #1.	
13.6.5	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.				
13.6.5.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.	Med. Mgmt. Appeals Policy and Procedure, pg. 7	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 7.	
13.6.5.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 6.	
13.7	**Expedited Resolution of Appeals**				
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize	Med. Mgmt. Appeals Policy and Procedure, pg. 4	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 4.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the member's life or health or ability to attain, maintain, or regain maximum function.				
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	Med. Mgmt. Appeals Policy and Procedure. Pg. 4	Full	The element language is found in the submitted policy, but not in the Provider Handbook. Recommendation: The MCO should add the required language to the Provider Handbook.	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	Med. Mgmt. Appeals Policy and Procedure, pg. 6	Full	The element language is stated in the submitted Appeals policy.	
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	Med. Mgmt. Appeals Policy and Procedure, pg. 10	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 10.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.	Med. Mgmt. Appeals Policy and Procedure, pg. 1	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 1.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Med. Mgmt. Appeals Policy and Procedure, pg 6	Not Met	The required language is not found in Med. Mgmt. Appeals Policy and Procedure, pg 6, and the process for notifying members of the opportunity to present evidence was not submitted for review. The MCO did not provide a response during the discussion onsite. Recommendation: The MCO should provide the process for notifying members of the opportunity to present evidence. In response to the draft report, the MCO will update the denial template to include the required language. The review determination remains as "note met."	ACLA is moving to update the denial template to include this language.
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	Member Handbook, pg 45	Substantial	The element language is stated in the Member Handbook; however, "no follow up required" was not found in the Appeals Policy. In response to discussing this issue onsite the MCO stated: The auditor's suggestion will be taken into consideration. The MCO indicated that it will amend the policy to include the language which captures the intent of the contract. However, ACLA allows members to file an appeal orally or in writing, without requiring additional follow up. Recommendation: The policy should be amended to include the language as stated by the MCO. In response to the draft report, the	The policy will be amended to include this language.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				MCO will update policies to include the required language. The review determination remains as "substantial."	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	Member Handbook, pg 45 Med. Mgmt. Appeals Policy and Procedure	Full	The requirement is stated in the Member Handbook (pg. 45) and in the Appeals Policy.	
13.8	**Continuation of Benefits**				
13.8.1	Terminology - As used in this section, "timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.				
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: • The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and • The member requests extension of benefits.	Med. Mgmt. Appeals Policy and Procedure, p. 7	Full	The submitted Appeals Policy states the contract language except for: "with the member's written consent." Template letters for process for notifying member of continuation of benefits were not submitted for review. In response to onsite discussion of this issue, the MCO stated: The language is found in the ACLA Appeals policy but is not exact contract language, as there is no requirement that the language be verbatim. See Continuation of Benefits section, page 7, #2. The language "at the member's written request" is contained in the first sentence which is accepted as meeting requirement.	
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails	Med. Mgmt. Appeals Policy and Procedure, pg. 7	Full	The submitted Appeals Policy contains the element language. The process for notifying members of continuation of benefits was not submitted for review, but was found on pg. 45 of the Member Handbook.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.				
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	Med. Mgmt. Appeals Policy and Procedure, pg. 8	Full	The contract language is included in the submitted Appeals Policy. The process for notifying members that the MCO may recover costs was not submitted for review, but was found on pg. 45 of the Member Handbook.	
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Handbook, pg. 126	Full	The Provider contract was not provided for review. The grievance language is included in the Provider Handbook. In response to onsite discussion of this issue, the MCO stated: Providers are made aware of the appeals and grievance procedures at the time of contracting via the Provider Handbook, which becomes part of the contract.	
13.10	**Recordkeeping and Reporting Requirements**				
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	Pre-onsite: Member Grievances Policy and Procedure, pg. 1 Grievance Reports, pg. 6 (was not submitted for review) Post-onsite:	Full	The contract language was not found in the submitted Grievance Policy. The referenced Grievance Reports, pg. 6 was not submitted for review prior to the onsite and no template grievance reports were submitted.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		170.201 Member Grievances (Page 7; Grievance Records and Reports) (Page 1; Policy) These documents were not found on the FTP post-onsite.		In response to onsite discussion of the issue, the MCO stated they would send screen shots to confirm submission and would submit the following which were not found uploaded to the FTP: 170.201 Member Grievances (Page 7; Grievance Records and Reports) (Page 1; Policy) The report, 112 ACLA 2016 05 (Member Grievance), and the Louisiana Monthly Appeals Report May 2016 indicate 6 of 10 DME appeals were overturned, 4 of 4 home health services appeals were overturned, and 10 of 25 pharmacy appeals were overturned. The MCO Analysis states that Hepatitis C appeals continue to account for the majority of pharmacy appeals. The MCO provided a screen shot dated June 15, 2016 as evidence of submission to DHH. The QCCC Committee meeting minutes FINAL 6 7 16 includes the following Appeals Analysis: Appealed services in order of frequency and outcomes: Durable Medical Equipment: 77% Overturned Patient Care Services: 66% Overturned Imaging: 66% Overturned Inpatient Admissions:50% Overturned PDHC: 100% Overturned Genetic Testing: 100% Overturned Physical Therapy: 100% Overturned	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Hospice: 100% Overturned Dismissed: 2: Lack of Member consent It should be noted that the case management file review included three member complaints regarding an inability to obtain an MRI, and that the above noted Appeals report shows the high percent of imaging appeals that are overturned.	
13.11	**Effectuation of Reversed Appeal Resolutions**				
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	Med. Mgmt. Appeals Policy and Procedure, pg. 11	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 11.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	Med. Mgmt. Appeals Policy and Procedure, pg. 11	Full	The requirement is met in Med. Mgmt. Appeals Policy and Procedure, pg. 11.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**				
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:				
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	2016 QAPI Program Description. Pg. 10	Full	The element is addressed in the 2015 and 2016 QAPI program descriptions (signed and dated copies were provided onsite), as well as in the 2016 QAPI Work Plan. Deficiencies in the subset elements were discussed during the onsite visit and were addressed as noted in the following sections with the submission of additional documentation after the onsite visit.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	Pre-onsite: 2016 QAPI Program Description Program Scope Pg. 11, Program Activities Pg. 30, and Medical and Treatment Record Audits Pg. 39 Post-onsite: 044 ACLA 2015 (Predictive Modeling Specs) 069 ACLA 2016 Q1 2016 IHCM Program Description ACLA 205.005 (Medical & Treatment Record Review) ACLA 205.300 (QOC Case Review)	Full	This element, including evidence of medical record audits and activities for health disparities, was discussed onsite and the requirements are met in the 2016 Program Description and Work Plan and in the following additional documentation provided post-onsite: 044 ACLA 2015 (Predictive Modeling Specs), 069 ACLA 2016 Q12016 IHCM Program Description, ACLA 205.005 (Medical & Treatment Record Review), and ACLA 205.300 (QOC Case Review).	
14.1.4	Detect and address underutilization and overutilization of services	2016 QAPI Program Description Quality Assessment and Performance Improvement Committee Pg. 14 Quality of Clinical Care Committee Pg. 16	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.1.5	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	Pre-onsite: 2016 Lumbar Spine CT Criteria References, Pg. 5 2016 Brain MRI Criteria References, Pg. 7 2016 Thoracic Spine MRI Criteria References, Pg. 5 Post-onsite: LDH Approval of NIA Subcontract	Full	The requirement is met in the submitted documentation: 2016 Lumbar Spine CT Criteria References, Pg. 5, 2016 Brain MRI Criteria References, Pg. 7, 2016 Thoracic Spine MRI Criteria References, Pg. 5, and LDH Approval of NIA Subcontract.	
14.1.6	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	Pre-onsite: 2016 QAPI Program Description, Physician Feedback, Pg. 28 LARC Fax Blast, LARC Reimbursement Rate, Pg. 1 IHCM Sickle Cell Blueprint, Program Goals, Pg.2 ADHD PIP, Entire Document, all pages Post-onsite: 2016 IHCM Program Description Appendix I – Dated Sickle Cell Blueprint per request 2016 QAPI Program Description (v. 2) Added language to QAPI PD for future reference	Substantial	The following deficiencies in the submitted 2016 QAPI Program Description were discussed with the MCO onsite: Physician Feedback, Pg. 28 does not address LARC, pain management for sickle cell, or ADHD behavioral therapy. The need for a dated and signed Sickle Cell Blueprint was also discussed. In response, the MCO submitted a revised 2016 QAPI Program Description that contains all contract language for this element as well as an undated, unsigned IHCM Program Description that addresses sickle cell care. Recommendation: The MCO submitted a revised 2016 QAPI Program Description outside of the review period to meet this requirement. The 2016 IHCM Program Description Appendix I – should be signed and dated. In response to the draft report, the MCO suggested that evidence of compliance with the requirement could be found in the QAPI meeting minutes. However, evidence of approval during the review period	Pursuant to Section 4.5.1 of the LDH contract: Reviewed policies shall be dated and signed by the MCO's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. The QAPI meeting minutes produced to evidence approval of the program description also cover adoption of its attachments. ACLA requests reconsideration of this determination.

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				of the revised 2016 program description, its attachments or policies related to this element could not be found in the submitted QAPI meeting minutes. The determination remains as "substantial."	
14.1.7	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	ADHD PIP Entire Document, all pages ADHD PA Criteria Drugs (Age Limits) Pg. 1	Full	The requirement is met in the submitted documents: ADHD PIP, and ADHD PA Criteria Drugs (Age Limits) Pg. 1.	
14.1.8.	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Pre-onsite: 2016 QAPI Program Description, Goals, Pg. 10 Post-onsite: PIP Meeting Minutes 14.1.8 FUH workgroup meeting minutes	Full	The element is addressed in the 2016 QAPI Program Description, Goals, Pg. 10, but not in the 2016 Work Plan. The MCO stated onsite that they would submit the IHCM Work Plan to meet this requirement. Although this document was not submitted post- onsite. Post-onsite, the MCO submitted the PIP and FUH workgroup meeting minutes which in addition to the QAPI Program Description meet this requirement.	
14.1.9	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	EHR Incentive Program Flyer, all pages 218 ACLA 2016 SA1 (LaHIE Participation Report) Reporting Data Tab – Analysis, Tab 2 ACLA Regulatory Notice Paragraph U, Pg. 2	Full	The requirement is met in the submitted documents: EHR Incentive Program Flyer, (all pages), 218 ACLA 2016 SA1 (LaHIE Participation Report) Reporting Data Tab – Analysis, Tab 2, and ACLA Regulatory Notice Paragraph U, Pg. 2.	
14.1.10	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all	Pre-onsite: 2016 QAPI Program Description Post-onsite: 2016 QAPI Program Description (v. 2) 14.1.10 HEDIS 2015	Substantial	The 2016 QAPI Program Description Pg. 39 addresses only the policy of collecting data. This issue was discussed onsite with the MCO. In response, the MCO submitted a revised 2016 QAPI Program Description inclusive of the	The HEDIS 2015 Race, Ethnicity & Language memo, data and report to the QAPI Committee is from the audit time period and evidences ACLA's compliance with this measure. ACLA requests reconsideration of this determination.

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.	Disparities Data 14.1.10 HEDIS 2015 Disparities Report 14.1.10 HEDIS 2015 Disparities Memo		element language as well as a HEDIS Disparities data, report, and a memo which meet the requirement but was completed after the review period. Recommendation: The MCO submitted a revised 2016 QAPI Program Description outside of the review period to meet this requirement. In response to the draft report, the MCO suggests that evidence of compliance with this requirement is found in previously submitted documents. However, this element specifically is to be "part of the QAPI program description" which was revised to meet the element after the review period. The review determination remains as "substantial."	
14.1.11	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	Pre-onsite: 2016 QAPI Program Description Post-onsite: 205.005 (Medical & Treatment Record Review) P&P 205.300 (Quality of Care Case Review) P&P	Full	Prior to the onsite, no P/P was submitted for review for this element nor does the 2016 QAPI Program Description address this element. In discussion onsite with the MCO, the following policies were submitted that meet the requirement: 205.005 (Medical & Treatment Record Review) P&P 205.300 (Quality of Care Case Review) P&P.	
14.1.12	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	Pre-onsite: 2016 QAPI Program Description, pg. 10 Post-onsite: 205.300 (Quality of Care Case Review) P&P ACLA Response: The LDH contract says, "The QAPI	Full	Prior to the onsite, no P/P was submitted for review. The 2016 QAPI Program Description Pg. 31-32 only addresses PIP activities, and does not provide evidence of implementation. The QAPI Work Plan does not contain status updates or evidence	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Program shall define…" We do not see a reference to a separate P&P and propose that this contract requirement is met via the QAPI Program Description as a whole, as summarized in the Purpose on page 10. Additional documentation meeting requirement submitted for other elements: as detailed below including QAPI committee meeting minutes.		of timing of implementation. The elements were discussed onsite with the MCO which submitted the following response: P&P 205.300 (Quality of Care Case Review) and the statement: The LDH contract says, "The QAPI Program shall define…" Post-onsite, (as described below in the QAPI Work Plan element) QAPI committee meeting minutes were accepted as evidence of QAPI Work Plan status updates and implementation. The above referenced materials were accepted as meeting the requirement.	
14.1.14	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	2016 QAPI Program Description	Full	The 2016 QAPI Program Description (pgs. 12 – 13), and the 2016 QI Work Plan meet this requirement.	
14.1.15	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Pre-onsite: 2016 QAPI Program Description Post-onsite: 2015 and 2016 CAHPS (Adult) and (Child) 14.1.15 Provider Feedback – QAPI meeting minutes ACLA Response: Member and provider feedback in not solicited via a written request; rather, it is obtained via our QAPI, QCCC and MAC committees and incorporated into various improvement	Full	The 2016 QAPI Program Description (pgs. 11, 16, and 45) address this element. Evidence of implementation, including the use of feedback reports was discussed onsite with the MCO, which provided the following response: Member and provider feedback is not solicited via a written request; rather, it is obtained via our QAPI, QCCC and MAC committees and incorporated into various improvement projects. An example of provider feedback includes QAPI Meeting Minutes	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		projects. For examples of provider feedback, see QAPI Meeting Minutes 2015Q4, page 7 and 11. For examples of member feedback, see 139 ACLA 2016Q1 (MAC Meeting Minutes).		2015Q4, page 7 and 11. Examples of member feedback include Policy 139 ACLA 2016Q1 (MAC Meeting Minutes). 14.1.15 Provider Feedback – QAPI meeting minutes. In addition to the above documents, the 2015 and 2016 Adult and Child CAHPS reports and evidence of their submission to LDH address this requirement.	
14.1.16	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.	Pre-onsite: 131 ACLA 2015 (QAPI PIP Outcomes) Post-onsite: Additional documentation meeting requirement submitted for other elements: QAPI committee meeting minutes, MAC meeting minutes, and 2015 and 2016 QAPI Program Evaluations and screenshot of submission to DHH	Full	The 131 ACLA 2015 (QAPI PIP Outcomes) Email addresses this element for the 2015 PIP only. Evidence of submission for all quality measure reporting was discussed onsite with the MCO, which stated most dissemination occurs via meeting minutes, or FAX Blasts to providers. Additional evidence submitted for other elements was found, including: QAPI committee meeting minutes, MAC meeting minutes, 2015 and 2016 QAPI Program Evaluations and a screenshot of submission to LDH which meets the requirement.	
14.1.17	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	2016 QAPI Program Description ADHD PIP ADHD PA Criteria	Full	The requirement is met in the following: 2016 QAPI Program Description Pg. 38 provides a link to the AAP ADHD clinical guidelines. The ADHD PIP provides evidence of provider education/engagement. The ADHD PA Criteria Pg. 1 states: that behavior modification therapy is attested to by Prescribers for Initial ADHD treatment.	
14.1.18	The MCO shall conduct peer review to evaluate the clinical competence and quality	Pre-onsite: 2016 QAPI Program	Full	The 2016 QAPI Program Description (pg. 41) addresses monitoring of	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	and appropriateness of care/services provided to members.	Description Post-onsite: 205.005 (Medical & Treatment Record Review) P&P 205.300 (Quality of Care Case Review) P&P 14.1.18 Sample MRR Audit 14.1.18 Sample TRR Audit 069 ACLA 2016Q1 (Medical Record Review) statutory report		some evidence based therapy practices. This element was discussed onsite. a P/P as well as peer review reports were provided as well as the following documents that meet this requirement: P/P 205.005 (Medical & Treatment Record Review), P/P 205.300 (Quality of Care Case Review), P/P 14.1.18 Sample MRR Audit, 14.1.18 Sample TRR Audit, and 069 ACLA 2016Q1 (Medical Record Review) statutory report.	
14.1.19	The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.	Pre-onsite: 2016 QAPI Program Description Post-onsite: PIP meeting minutes ACLA Response: LDH has not convened an "Interdepartmental Monitoring Team (IMT") meeting; however, we are including minutes from LDH's PIP meetings.	Full	The IMT meeting minutes were not submitted for review but the 2016 QAPI Program Description Pg. 23 addresses this element. In response to discussing this issue onsite, the MCO submitted PIP meeting minutes and the statement: LDH has not convened an "Interdepartmental Monitoring Team (IMT") meeting; however, we are including minutes from LDH's PIP meetings.	
14.1.20 14.1.20.1 14.1.20.2	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	Pre-onsite: 320 ACLA 2016 Q2 Post-onsite: ACLA Response: We do not see a contract reference to a separate P&P and propose that this requirement is met via our submission of the referenced reports on LDH's template.	Full	The 320 ACLA 2016 Q2 is dated for April, with this statement: No data to report at this time. As of 6/22/16 per OBH, ACT reporting on the Fidelity Monitoring Report (319) and Behavioral Health Treatment Outcomes Report (320) is on hold until further guidance is issued by LDH. The lack of a P/P, outcome measurement and evidence of sharing with LDH were discussed with the MCO onsite, which responded: We do not see a	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				contract reference to a separate P&P and propose that this requirement is met via our submission of the referenced reports on LDH's template. As noted above (14, 1.18), the MCO submitted a sample TRR Audit, which is a redacted, undated single case review for a member with ADHD. Post-onsite, 329 ACLA BH UM report was found to address this requirement.	
	For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual base.	320 ACLA 2016 Q2 333 (Strategy for Increasing Outcomes) – LDH Template; 1st submission due 1/30/2017	Full	Met as noted in the above element.	
14.2	**QAPI Committee**				
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:				
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	Pre-onsite: 2016 QAPI Program Description QAPI Meeting Minutes (2015Q4, 2016Q1, 2016Q2, and 2016Q3)	Full	The QAPIC meeting minutes 2015Q4 show the Medical Director is co-chair and was present. The 2016 QAPI Program Description Pg. 14 addresses this element for 2016.	
14.2.1.2	The MCO Behavioral Health Director;	2016 QAPI Program Description QAPI Meeting Minutes (2015Q4, 2016Q1, 2016Q2, and 2016Q3)	Full	The 2016 QAPI Program Description Pg. 15 addresses this element. 2015Q4 meeting minutes indicate the MCO BH director was present.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	2016 QAPI Program Description QAPI Meeting Minutes	Full	The 2016 QAPI Program Description Pg. 14 addresses this element.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		(2015Q4, 2016Q1, 2016Q2, and 2016Q3)		2015Q4 meeting minutes show the director of QM and other appropriate staff present.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	2016 QAPI Program Description QAPI Meeting Minutes (2015Q4, 2016Q1, 2016Q2, and 2016Q3)	Full	The 2016 QAPI Program Description (pg. 15) addresses this element. The submitted 2015Q4, and 2016 Q1-Q3 meeting minutes indicate a community education representative was present, rather than a member advocate. The MCO stated onsite that their community education representative works as a member advocate in the community.	
14.2.1.5	The MCO shall include DHH representative(s) on the QAPI Committee, as designated by DHH as non-voting member(s).	2016 QAPI Program Description QAPI Meeting Minutes (2015Q4, 2016Q1, 2016Q2, and 2016Q3)	Full	The 2016 QAPI Program Description (pg. 15) addresses this element. The 2015Q1 indicates a LDH representative was present via teleconference for this one meeting.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	Pre-onsite: 2016 QAPI Program Description QAPI Meeting Minutes (2015Q4, 2016Q1, 2016Q2, and 2016Q3) Post-onsite: 2015 QAPI Program Description (signed/dated)	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg. 15), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.1	Direct and review quality improvement (QI) activities;	2016 QAPI Program Description (signed/dated)	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg. 13), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	2016 QAPI Program Description	Full	The element is met in the 2015 and 2016 QAPI Program Description (pgs. 13-14), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.3	Review and suggest new and or improved QI	2016 QAPI Program	Full	The element is met in the 2015 and	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	activities;	Description		2016 QAPI Program Description (pg.14), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	2016 QAPI Program Description	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg.14), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.5	Designate evaluation and study design procedures;	2016 QAPI Program Description	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg.14), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	Pre-onsite 2016 QAPI Program Description Post-onsite: P&P 205.005 (Medical & Treatment Record Review) P&P 205.300 (Quality of Care Case Review)	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg.14), the 2016 QAPI Work Plan, the submitted quarterly QAPI meeting minutes, and in the following documents submitted post-onsite: P&P 205.005 (Medical & Treatment Record Review) P&P 205.300 (Quality of Care Case Review).	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	2016 QAPI Program Description	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg.13), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	2016 QAPI Program Description Key Performance Indicator Dashboard ER Utilization 2016 Q2	Full	The element is met in the 2015 and 2016 QAPI Program Description (pg.16), the 2016 QAPI Work Plan, and the submitted quarterly QAPI meeting minutes. The Key Performance Indicator Dashboard for the month of August 2016 and ER Utilization 2016 Q2 provide evidence of implementation.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting	Pre-onsite: 2016 QAPI Program	Full	The requirement is addressed in the 2016 QAPI Program Description	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	minutes to DHH;	Description Post-onsite: 119 ACLA 2015Q4 – 2016Q2 (QAPI Meeting Minutes). Note: LDH changed its report submission protocol in October 2016. Reports are now uploaded to an LDH SharePoint site; therefore, there is no email trail.		(pg.15) and in the quarterly QAPI meeting minutes. The lack of sub-committee meeting minutes and evidence of submission of all committee meeting minutes to LDH was discussed onsite with the MCO. The MCO provided the following response: LDH changed its report submission protocol in October 2016. Reports are now uploaded to an LDH SharePoint site; therefore, there is no email trail.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management services;	2016 QAPI Program Description 216 ACLA 2015 (QAPI Program Evaluation)	Full	The 2016 QAPI Program Description Pg. 43, and the 2106 ACLA 2015 (QAPI Program Evaluation) meet this requirement.	
14.2.2.11	Ensure that the QAPI committee chair attends DHH quality meetings; and	Pre-onsite: 2016 QAPI Program Description Post-onsite: 14.2.2.11 Dr. Wise's Calendar invite	Full	The 2016 QAPI Program Description Pg. 23 and screen shot 14.2.2.11 meet this element.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	2016 QAPI Program Description	Full	The 2016 QAPI Program Description meets this requirement.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	Pre-onsite: 2016 QAPI Program Description 121 ACLA 2015 (QAPI Program Description & Work Plan) Post-onsite: 14.2.3 QCCC Agenda 14.2.3 QCCC work plan memo	Full	The 2016 QAPI Program Description Pg. 43 and the 121 ACLA 2015 (2016 QAPI Program Description & Work Plan) dated 2-1-16 meet this element. The MCO explained onsite that 121 ACLA provides evidence of submission of the 2016 Work Plan and Program Description. The MCO also submitted the following documents as evidence of Work Plan implementation: 14.2.3 QCCC Agenda 14.2.3 QCCC work plan memo.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	2016 QAPI Work Plan Post-onsite: 14.2.3 QCCC Agenda, and 14.2.3 QCCC work plan memo are dated outside the RP and detail changes in staff and timelines; does not reflect progress or evaluation of the QI program; no status updates	Full	The 2016 QAPI Program Description addresses this element and the Work Plan documents planning but it is does not document decision making, interventions and assessment of results as there is no "updates/status" column or section. In responses to an inquiry onsite about how implementation is documented in the Work Plan the MCO stated that this requirement is addressed in separate memos created to update the QOC Committee on Work Plan changes prior to each meeting rather than documented within the Work Plan. Recommendation: The QAPI Work Plan should also contain status columns/sections to reflect planning, decision making, intervention and assessment of results within the document, in addition to the separate memo. In this way, progress and implementation is readily accessible for tracking purposes.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	2016 QAPI Program Description	Full	The 2016 QAPI Program Description Pg. 43 addresses this element; the Work Plan has evidence of planning but not of implementation. Recommendation: As stated above In 14.2.3.1	
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	2016 QAPI Program Description	Substantial	The 2016 QAPI Program Description addresses this element. Quality Management Roles & Responsibilities Pg. 23-27 lists QAPI program staff titles and their responsibilities but not their specific required educational background or credentials (except for MD for Medical Director), i.e., RN, LSW, or	This contract provision does not require the level of detail (i.e., education or credentials) requested in the recommendation. As the specific person filling each role may change on occasion, it is not recommend to include person details on the individual. We believe the contract

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				B.S. It does note the training they receive relative to their job. Recommendation: The MCO should provide a description of the credentials of the QAPI staff and/or an organizational chart that would include this information. In response to the draft report, the MCO clarified the requirement. As a result, the recommendation has been revised to the following: the MCO should clarify with LDH whether training for this element includes personal level of educational training and credentials of the QAPI staff, or whether broad training descriptions for all staff are sufficient. The review determination remains as "substantial."	provision is met via the inclusion of the title, responsibilities and training of QAPI members and overview of committee structure. For these reasons, we request reconsideration of this determination.
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	2016 QAPI Program Description	Full	The 2016 QAPI Program Description Practitioner Participation Pg. 27 meets the requirement.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	2016 QAPI Program Description	Full	The 2016 QAPI Program Description and 2016 Work Plan do not have references to other State's programs and meet the requirement.	
14.2.3.6	Describe the methods for ensuring data collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	Pre-onsite: 2016 QAPI Program Description Post-onsite: 205.005 (Medical & Treatment Record Review) 044 ACLA 2015 (Predictive Modeling Specs) ACLA Response: While we do not see a contract reference to a separate P&P, we	Full	The 2016 QAPI Program Description partially addresses the element, but does not detail methods. In response to the onsite inquiry about this issue, the MCO submitted the P/P 205.005 (Medical & Treatment Record Review) which describes the process for evaluating provider adherence to CPGs and meets the requirement.	

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		propose that the attached ACLA 205.005 (Medical & Treatment Record Review) P&P speaks to providers' adherence to CPGs. We are also including 044 ACLA 2015 (Predictive Modeling Specs) as a description of our data collection processes and validity.		The MCO also submitted the following post-onsite: 044 ACLA 2015 (Predictive Modeling Specs).	
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	Pre-onsite: 2016 QAPI Program Description Post-onsite: 205.005 (Medical & Treatment Record Review) ACLA Response: The fidelity monitoring plan is incorporated into the QAPI Program Description and is not maintained in a separate document.	Full	The 2016 QAPI Program Description, Pg. 40 which details all elements of the fidelity monitoring plan meets the requirement.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Results of the evaluation of the impact and effectiveness of the QAPI program.	131 ACLA 2015 (QAPI PIP Outcomes) 216 ACLA 2015 (QAPI Program Evaluation)	Full	The QI annual 2015 and 2016 program evaluations meet this requirement.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.	2016 QAPI Program Description 329 ACLA 2015 – 2016 (Children in Restrictive Settings	Full	The 2016 QAPI Program Description, Pg. 43 Reporting & Evaluation, addresses the element in general language, but not the specific language requirements. The submitted Excel reports meet requirement for children in restrictive settings. In response to an inquiry onsite about whether additional reports are available or required, specifically related to special	

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				populations (e.g., DCFS, OJJ) the MCO stated the PIP report is another example of an ad hoc report, and that the emails provide evidence of submission to LDH.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the *MCO Quality Companion Guide and the Behavioral Health Companion Guide.*	Pre-onsite: 2016 HEDIS IDSS (Administrative PM data removed from Quality reporting) Post-onsite: 2015 and 2016 CAHPS (Adult) and (Child)	Full	The 2016 HEDIS IDSS includes all measures except Flu Vaccinations for Adults and Medical Assistance with Smoking, which were reported in the Adult CAHPS submission. All Incentive measures were reported except, Follow-up after Hospitalization for Mental Illness which the MCO stated onsite will be reported for the first time next year.	
14.2.5.2	The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.	Pre-onsite: 2016 HEDIS IDSS 2016 Non-HEDIS Measures Report 2016 CAHPS (Adult) 2016 CAHPS (Child) ACLA CAHPS FTP Submission Post-onsite: 2015 CAHPS (Adult) 2015 CAHPS (Child)	Full	The 2016 HEDIS IDSS, 2016 Non-HEDIS Measures Report, 2015 and 2016 CAHPS (Adult and Child), and ACLA CAHPS Submission meet this requirement.	
14.2.5.3	The MCO shall have processes in place to monitor and self-report all performance measures.	2016 QAPI Program Description 2016 HEDIS Compliance Final Audit Report	Full	The 2016 QAPI Program Description Pg. 32 and the 2016 HEDIS Compliance Final Audit Report addresses this element.	
14.2.5.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	ACLA IPRO FTP Submission	Full	The ACLA IPRO FTP Submission meets this requirement.	
14.2.5.5	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	Administrative PMs removed from Quality reporting; the following sample administrative PM statutory reports are attached: 107 ACLA 2016 07 (Member Call Center) 112 ACLA 2016 (Member Grievance)	Full	The MCO stated onsite that Administrative PMs are no longer required for Quality reporting and submitted the following post-onsite statement: The following sample administrative PM statutory reports meet this requirement: 107 ACLA 2016 07 (Member Call Center) and 112 ACLA 2016 (Member Grievance)	

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				Emails & attached reports.	
14.2.5.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Pre-onsite: 2016 QAPI Program Description Post-onsite: ACLA Response: We do not see a contract reference to a separate P&P and propose that this requirement is met via submission of our QAPI Program Description.	Full	Post-onsite, signed and dated copies of the 2015 and 2016 QAPI Program Descriptions were submitted and address this requirement. Recommendation: As discussed onsite, the MCO should include the element language in a policy so that its employees have a reference for implementing the contract.	
14.2.5.7	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Pre-onsite: 2016 QAPI Program Description Post-onsite: ACLA Response: We do not see a contract reference to a separate P&P and propose that this requirement is met via submission of our QAPI Program Description.	Full	Post-onsite, signed and dated copies of the 2015 and 2016 QAPI Program Descriptions were submitted and address this requirement. Recommendation: As discussed onsite, the MCO should include the element language in a policy so that its employees have a reference for implementing the contract.	
14.2.5.8	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	Pre-onsite: 2016 QAPI Program Description Post-onsite: ACLA Response: We do not see a contract reference to a separate P&P and propose that this requirement is met via submission of our QAPI Program Description.	Full	Post-onsite, signed and dated copies of the 2015 and 2016 QAPI Program Descriptions were submitted and address this requirement. Recommendation: As discussed onsite, the MCO should include the element language in a policy so that its employees have a reference for implementing the contract.	
14.2.5.9 14.2.5.9.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$."	2016 HEDIS IDSS 2016 Non-HEDIS Measures Report	Full	The 2016 HEDIS IDSS and 2016 Non-HEDIS Measures Report meet this requirement.	
14.2.5.9.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will				

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	be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.				
14.2.5.10	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.	Pre-onsite: This element does not contain an MCO deliverable. Post-onsite: ACLA Response: There is no MCO deliverable for these elements.	Full	A Performance Measurement P/P was not submitted for review. The MCO stated onsite that LDH has not yet provided the goals for 2016 and stated that the requirement is addressed in the contract so that a policy is not required.	
14.2.5.11 14.2.5.11.1	**Performance Measures Reporting** All measures contained in Appendix J MCO Performance Measures and the Behavioral Health Companion Guide are reporting measures.				
	14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH. 14.2.5.11.5 The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re- submissions. 14.2.5.11.6 The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.	2016 HEDIS IDSS 2016 Non-HEDIS Measures Report 2016 HEDIS Compliance Final Audit Report	Full	The 2016 HEDIS IDSS, 2016 Non-HEDIS Measures Report, and 2016 HEDIS Compliance Final Audit Report meet this requirement.	
14.2.5.12	**Performance Measure Goals** 14.2.5.12.1 The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the Bayou Health population.	Pre-onsite: This element does not contain an MCO deliverable. Post-onsite: ACLA Response: There is no MCO deliverable for these elements.	Full	The MCO stated onsite that LDH has not yet provided the goals for 2016 and stated that the requirement is addressed in the contract so that a policy is not required.	

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14.2.5.12.3	DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee. Final determination of goals is at the sole discretion and approval of DHH	Pre-onsite: This element does not contain an MCO deliverable. Post-onsite: ACLA Response: There is no MCO deliverable for these elements.	Full	The MCO stated onsite that LDH has not yet provided the goals for 2016 and stated that the requirement is addressed in the contract so that a policy is not required	
14.2.5.13	**Performance Measure Reporting** 14.2.5.13.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring. 14.2.5.13.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH. **Reporting Measures.** 14.2.5.13.4 The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting.	Pre-onsite: 2016 QAPI Program Description Provider Performance Report Post-onsite: 205.005 (Medical & Treatment Record Review) Provider Performance Report – pg. 3	Full	The 2016 QAPI Program Description Pg. 32 addresses this element except for "The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting." Post-onsite P/P 205.005 was submitted and addresses this requirement. The Provider Performance Report provides evidence of reviewing Provider HEDIS results but it does not provide evidence of onsite medical record review at PCP's and LMHP's offices as stated in the policy submitted post-onsite. MRR tools and MRR results were requested onsite, but have not yet been submitted for review. Recommendation: The MCO should submit MRR tools and PCP clinical quality profile reports from PCP onsite MRR as indicated in P/P205.005. In response to the draft report, the MCO submitted MRR tools and MRR results (069 2015 Q4 MRR Summary Report and QCC Annual Record Review Memo. The MCO submitted an example of MRR results by provider and a summary memo of provider profile results during the	Please see attached 069 2015 Q4 (MRR Summary Report) and QCC Annual Record Review Memo. We request reconsideration of this determination as fully compliant as evidenced by these attachments.

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				review period (calendar year 2015) meeting this requirement. The review determination has been changed to "full."	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.240.	ADHD PIP Prematurity PIP	Full	The MCO has submitted all requested ADHD PIP components. The required Prematurity PIP baseline PIP report was submitted to IPRO with revisions.	
14.2.8.2	The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. DHH may require up to two (2) additional projects for a maximum of four (4) projects.	ADHD PIP Prematurity PIP	Full	The requirement is met as noted above for element 14.2.8.1.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.	ADHD PIP	Full	The requirement is met as noted above for element 14.2.8.1.	
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective quality indicators; • Implementation of system interventions to achieve improvement in quality; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	2016 QAPI Program Description ADHD PIP Prematurity PIP	Full	The requirement is met as noted above for element 14.2.8.1.	
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, as well as its relevance to the MCO members and providers;	ADHD PIP Prematurity PIP	Full	The requirement is met as noted above for element 14.2.8.1.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	• The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.				
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;	ADHD PIP Prematurity PIP	Full	The requirement is met as noted above for element 14.2.8.1.	

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	• Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.				
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	Pre-onsite: 2016 CAHPS (Adult) 2016 CAHPS (Child) Post-onsite: 2015 CAHPS (Adult) 2015 CAHPS (Child)	Full	The 2015 and 2016 CAHPS (Adult) and (Child) meet this requirement.	
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	Pre-onsite: NCQA-Certified CAHPS Vendor List 2016 (Morpace) Post-onsite: CAHPS Contract with Morpace	Full	The NCQA-Certified CAHPS Vendor List 2016 Column 2 (Morpace) Pg. 1 addresses this element. The CAHPS Vendor contract was submitted post-onsite and meets this requirement.	
14.2.10.4	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	Pre-onsite: 2016 CAHPS (Adult) 2016 CAHPS (Child) Post-onsite: 2015 CAHPS (Adult) 2016 CAHPS (Child)	Full	The 2015 and 2016 CAHPS (Adult) and (Child) meet this requirement.	
14.2.10.5	The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey	ACLA CAHPS FTP Submission	Full	The ACLA CAHPS FTP Submission Screenshot of submission to IPRO meets this requirement.	

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	shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.				
14.2.10.6	The surveys shall provide valid and reliable data for results.	Pre-onsite: 2016 CAHPS (Adult) 2016 CAHPS (Child) Post-onsite: CAHPS Contract with Morpace	Full	The 2015 CAHPS Vendor contract was submitted post-onsite and meets the requirement.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	2016 CAHPS (Adult) 2016 CAHPS (Child)	Full	2016 CAHPS (Adult) and 2016 CAHPS (Child) meet the requirement.	
14.2.10.8	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Global Ratings.	2016 CAHPS (Adult) 2016 CAHPS (Child)	Full	2016 CAHPS (Adult) and 2016 CAHPS (Child) meet the requirement.	
14.2.10.9	The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.	Pre-onsite: BH Survey received from LDH on 9/23/16. Plans to administer in Qtr 1 2017. Post onsite: ACLA Response: A P&P is not required by the contract. ACLA is working with our member survey vendor to finalize the BH survey recently received from LDH.	N/A	No documentation was submitted for this element. The MCO stated onsite that the BH Survey was received from LDH on 9/23/16 and that they plan to administer it in Qtr 1 2017. The MCO also stated that Morpace will be the vendor for this survey, and a copy of the vendor agreement was requested onsite by IPRO. Te MCO is currently working with their member survey vendor to finalize the BH survey recently received from LDH.	
14.4	**Health Plan Accreditation**				
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	ACLA NCQA Certificate ACLA NCQA Final Letter	Full	The ACLA NCQA Certificate and Final Letter meet this requirement.	
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the	ACLA NCQA Certificate ACLA NCQA Final Letter	Full	The ACLA NCQA Certificate and Final Letter meet this requirement.	

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	accreditation requirements.				
14.4.3	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	ACLA NCQA Certificate ACLA NCQA Final Letter	Full	The ACLA NCQA Certificate and Final Letter meet this requirement.	
14.5	**Member Advisory Council**				
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	Pre-onsite: 141 ACLA 2015 (MAC Annual Plan Post-onsite: 039 ACLA 2015Q4 – 2016Q2 (MAC Meeting Minutes). Note: LDH changed its report submission protocol in October 2016. Reports are now uploaded to an LDH SharePoint site; therefore, there is no email trail.	Full	The submitted documents provide evidence of establishment of a MAC.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Pre-onsite: 141 ACLA 2015 (MAC Annual Plan) Post-onsite: 039 ACLA 2015Q4 – 2016Q2 (MAC Meeting Minutes). Note: LDH changed its report submission protocol in October 2016. Reports are now uploaded to an LDH SharePoint site; therefore, there is no email trail.	Full	The 141 ACLA 2015 (MAC Annual Plan) Pg. 1 states that the Council is to be chaired by the AmeriHealth Caritas Louisiana's Director of Community Education and Outreach or other designee. Meeting minutes were supplied for two quarters of the RP, and the September 15, 2015 minutes were found on the MCO website.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and	Pre-onsite: 141 ACLA 2015 (MAC Annual Plan) Post-onsite: 039 ACLA 2015Q4 – 2016Q2 (MAC Meeting Minutes).	Substantial	The 141 ACLA 2015 (MAC Annual Plan) Pg. 1 addresses this element, but does not state that at least one family member/caregiver of a child with special health care needs shall have representation on the committee. Post onsite, the MCO submitted	ACLA will update the MAC annual plan with this language. While we have special needs advocacy groups and community partners on our MAC, we have been unable to recruit a family member / caregiver of a special needs child. We are working diligently

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	member advocacy groups shall make up at least fifty per cent (50%) of the membership.			MAC meeting minutes for two meetings in the RP (11-5-15, and 2-23-16). No members are identified as being in attendance on the 2-23-16 minutes, and the 11-5-15 minutes identify one member as a dial-in attendee, although whether this member is a family member/caregiver of a child with special health care is not indicated. Recommendation: The MCO should add the contract language, "at least one family member/caregiver of a child with special health care needs shall have representation on the committee" to the MAC Annual plan and should provide evidence of the Member Advisory Council composition in compliance with this requirement.	to fulfill this requirement.
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	MAC Training Presentation	Full	The MAC Training Presentation y addresses the element.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter.	141 ACLA 2015 (MAC Annual Plan) 141 ACLA 2015 (MAC Annual Plan) – LDH Submission	Full	The 141 ACLA 2015 (MAC Annual Plan) and – LDH Submission meet the requirement.	
14.5.6.	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	MAC Webpage ACLA MAC Meeting Invite	Substantial	The meeting minutes for September 15, 2015 and November 5, 2015, are available in English on the MCO MAC webpage. Recommendation: All agenda and MAC council minutes for the RP should be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	ACLA will add the MAC agendas to our member website in English and Spanish. We will translate our MAC minutes into Spanish and post to our website as well.

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.6	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Family Functional Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards are met. A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted to DHH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.	Pre-Onsite: 2016 QAPI Program Description 319 ACLA 2016 Q2 (Fidelity Monitoring Plan) Post Onsite: FFT – Permission Forms Homebuilders - MOU MST - MOU ACLA's fidelity monitoring plan is incorporated into the QAPI program description and is not maintained in a separate document.	Full	The 2016 QAPI Program Description Pgs. 40-42, addresses this element. The 319 ACLA 2016 Q2 (Fidelity Monitoring Plan) shows rates for April 1, 2016-June 30, 2016 only. After discussing with the MCO onsite, they submitted the following: FFT – Permission Forms (some of which were signed after the review period), Homebuilders – MOU (signed within the review period, 7-22-16), MST – MOU (signed within the review period, 7-22-16), and the statement: ACLA's fidelity monitoring plan is incorporated into the QAPI program description and is not maintained in a separate document.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.8	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management. The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	ACLA 205.107 (Adverse Incident Reporting)	N/A	The P/P ACLA 205.107 (Adverse Incident Reporting) addresses this element. The MCO stated onsite that the Behavioral Health Companion Guide drafted by LDH was not in effect for the review period.	

Reporting					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
18.0	**Reporting**				
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	Management Information Report Sample	Full	The evidence provided includes monthly data regarding call center information, utilization, grievances and appeals, and member disenrollment.	

Fraud, Waste and Abuse					
Contract Reference	**Contract Requirement Language**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
15.1	**General Requirements**				
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S 46:437.1-437.14; LAC 50:1.4101-4235.				
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect, and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	2016 ACLA Compliance Program Description; Structural Organization: Compliance Office, Director of Compliance & Regulatory Affairs, page 2.	Full	This requirement is met by the following: On page 2 of the plan's Compliance Program Description, it states "The Director of Compliance and Regulatory Affairs serves as ACLA's primary point of contact on issues related to fraud, waste, and abuse prevention. The Director of Compliance and Regulatory Affairs, together with ACLA"s Market President and/or Director of Plan Operations and Administration, shall meet quarterly and upon request with DHH's Program Integrity Unit and OIG's Medicaid Fraud Control Unity (MFCU)."	
15.1.3	The MCO shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Agency Collaboration & Rights of Access, page 9.	Full	The requirement is stated on page 9 of the Compliance Program Description.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Agency Collaboration & Rights of Access, page 9.	Substantial	The requirement is stated on page 10 of the Compliance Program Description. However, it is not stated that requests for information will be compiled in the form and language requested. Recommendation: The MCO should add this language to the Program Description and ensure that MCO staff are aware of this component of the requirement. In response to the draft report, the MCO submitted as evidence of compliance, a response that the MCO submitted to an OIG request for data. While this evidence demonstrates partial compliance, it does not replace the need to have the required language incorporated into the MCOs Compliance Program Description. The determination remains as "substantial."	ACLA has demonstrated compliance with this section via numerous responses to requests during the audit period, as evidenced by the attached OIG Pharmacy Data Request email. We will include this clarification in our 2017 Compliance Program Description; however, we request reconsideration of this determination based on the attached proof of compliance.
15.1.5	MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Agency Collaboration & Rights of Access, page 9.	Full	The requirement is stated on page 9 of the Compliance Program Description.	
15.1.6	The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Agency Collaboration & Rights of Access, page 9.	Full	Page 10 of the Compliance Program Description states that the MCO and its subcontractors will make available member grievance and appeals files. However, there is no documentation regarding the monitoring of enrollment and termination practices within the Program Description, and there is no other submitted documentation that covers this component of the requirement.	The monitoring of enrollment and termination practices is an LDH (not MCO) function. (See highlight.) ACLA cannot create a policy defining LDH's practices for monitoring enrollment, termination and proper implementation of MCO grievance procedures. We request reconsideration of this determination.

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The MCO should develop a Policy & Procedure which outlines the monitoring of enrollment and termination practices and ensuring of proper implementation of the MCO's grievance procedure. In response to the draft report, the MCO clarified why the section of the regulation related to monitoring and termination is LDH responsibility and not the responsibility of the MCO. The review determination has been changed to "full."	
15.1.7	The MCO shall certify all statements, reports, and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Statement, Report & Claim Certification, page 10.	Full	The requirement is stated verbatim on page 10 of the Compliance Program Description.	
15.1.8	The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program to their designated Program Integrity contact.	2016 ACLA Compliance Program Description; Program Elements: Fraud, Waste & Abuse, Notifications & Reporting, page 10.	Full	The requirement is stated on page 10 of the Compliance Program Description.	
15.1.9	The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.1, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Response & Prevention, page 6. 2016 ACLA CPD Exhibit 2 (161.100.001—PI Overview of Responsibilities)	Full	The requirement is stated on page 6 of the Compliance Program Description, which references Policy No. 106.100.001. This policy is designed to "prevent, detect, investigate, and report fraud and abuse" and "safeguards against the potential for, and promptly investigates reports of, suspected fraud and abuse," as stated in the	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Purpose of the policy, on page 2.	
15.1.10	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 7. Disclosure of Ownership & Controlling Interest Statement, page 2.	Full	The requirement is stated on page 7 of the Compliance Program Description. Additionally, the Health Plan provided an example of its Facility Enrollment Form, which contains a page entitled "Disclosure of Ownership & Controlling Interest Statement."	
15.1.11	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 7. ACFC 106.100.014 (Prohibited Affiliations) ACFC 115.139 (Pre and Post-Employment Screening), page 2.	Full	The requirement is stated on page 7 of the Compliance Program Description. Additionally, Policy & Procedure No. 115.139: Pre- & Post- Employment Screening, page 2, affirms that employees will be screened against the exclusion list monthly. Further, the Plan provided Policy No. 106.100.014: Prohibited Affiliations as evidence of the procedures used to ensure this regulation is met.	
15.1.12	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	2016 ACLA Compliance Program Description; Auditing, Structural Organization: Compliance Office, SIU Investigators, page 2.	Full	The requirement is stated verbatim on page 2 of the Compliance Program Description.	
15.1.13	The MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a	2016 ACLA Compliance Program Description; Prohibitions: Recoveries, page	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	12.			
15.1.13.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	2016 ACLA Compliance Program Description; Prohibitions: Recoveries, page 12.	Full	The requirement is addressed on page 12 of the Compliance Program Description.	
15.1.13.2	The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or	2016 ACLA Compliance Program Description; Prohibitions: Recoveries, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	
15.1.13.3	When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal of State litigation or investigation, or are being audited by the Louisiana RAC.	2016 ACLA Compliance Program Description; Prohibitions: Recoveries, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	
15.1.14	This prohibition described above in Section 15.1.13 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery, recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.	2016 ACLA Compliance Program Description; Prohibitions: Recoveries, page 12.	Full	The requirement is addressed on page 12 of the Compliance Program Description.	
15.1.15	The MCO shall comply with all federal and state requirements regarding fraud, waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.	2016 ACLA Compliance Program Description; Overview, page 1. 2016 ACLA CPD (Exhibit 2 (161.100.001—PI Overview of Responsibilities).	Full	Page 1 of the Compliance Program states "This comprehensive Compliance Program is designed to comply with applicable federal and state laws relating to…fraud, waste, and abuse prevention." As further evidence, the Plan provided Policy 106.100.001: Overview of Responsibilities, which outlines the procedures in place for detecting, preventing, investigating, and reporting potential instances of fraud, waste, and abuse	
15.1.16	Reporting and Investigating Suspected Fraud and Abuse				
15.1.16.1	The MCO shall cooperate with all appropriate				

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	state and federal agencies, including MFCU, in investigating fraud and abuse.				
15.1.16.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	2016 ACLA Compliance Program Description; Overview, page 1. 2016 ACLA CPD (Exhibit 2 (161.100.001—PI Overview of Responsibilities).	Full	Page 6 of the Compliance Program Description states "ACLA utilized procedures for ongoing monitoring and auditing of plan systems. The MCO's Program Integrity Overview of Responsibilities (attached as Exhibit 2) outlines the multiple tracking and analysis methods for monitoring fraud, waste, and abuse." Policy 106.100.001 outlines the responsibilities of the Program Integrity Department, and under "Applicable Party(s)," subcontractors are listed.	
15.1.16.3	The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when concerns and/or allegations of any tips are authenticated.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	The requirement is addressed on page 10 of the Compliance Program Description.	
15.1.16.4	The MCO shall report all tips, confirmed or suspected fraud, waste, and abuse to DHH and the appropriate agency as follows:	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 11.	Full	The requirement is addressed on page 11 of the Compliance Program Description.	
15.1.16.4.1	All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to DHH and MFCU;	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 11.	Full	The requirement is stated verbatim on page 11 of the Compliance Program Description.	
15.1.16.4.2	Suspected fraud and abuse in the	2016 ACLA Compliance	Full	The requirement is stated verbatim	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	administration of the program shall be reported to DHH and MFCU;	Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 11.		on page 11 of the Compliance Program Description.	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 11.	Full	The requirement is stated verbatim on page 11 of the Compliance Program Description.	
15.1.16.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 11.	Full	The requirement is stated verbatim on page 11 of the Compliance Program Description.	
15.1.16.5	The MCO shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Timeframes, page 10.	Full	The requirement is stated verbatim on page 10 of the Compliance Program Description.	
15.1.16.6	The MCO shall be subject to civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to DHH MFCU, as appropriate.				
15.1.16.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigation and Prohibitions; Contact & Negotiations, page 12.	Full	The requirement is addressed on page 12 of the Compliance Program Description.	
15.1.16.7.1	Contact the subject of the investigation about any matters related to the investigation;	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigation and Prohibitions; Contact & Negotiations, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	
15.1.16.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigation and Prohibitions; Contact & Negotiations, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1.16.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigation and Prohibitions; Contact & Negotiations, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	
15.1.16.8	The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigation, page 12.	Full	The requirement is stated verbatim on page 12 of the Compliance Program Description.	
15.1.16.9	The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Agency Collaboration & Rights of Access, page 9.	Full	The requirement is addressed on pages 9-10 of the Compliance Program Description.	
15.1.16.10	The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.	ACFC 106.100.015 (State-Initiated Provider Payment Suspension)	Full	Policy 106.100.015: State-Initiated Provider Payment Suspension" describes the plan's procedures to meet this requirement.	
15.1.17	The State shall not transfer its law enforcement functions to the MCO.				
15.1.18	The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Agency Collaboration & Rights of Access, page 9. ACLA Sample Remit Advice	Full	The requirement is addressed on pages 9-10 of the Compliance Program Description.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.				
15.1.19	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Response & Preventions, page 7. ACLA Provider Agreement Template (PCP), Section 9.3(c), page 12.	Full	The requirement is addressed on page 7 of the Compliance Program Description, as well as in Section 9.3(c) of the Plan's PCP Agreement.	
15.1.20	The MCO shall notify DHH when the MCO denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	The requirement is addressed on page 10 of the Compliance Program Description.	
15.1.21	Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.				
15.1.22	In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the MCO shall report overpayments made by DHH to the MCO, as well as overpayments made by the MCO to a provider and/or subcontractor.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	The requirement is addressed on page 10 of the Compliance Program Description.	
15.1.23	The MCO shall have at least one (1) full-time investigator for full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	2016 ACLA Compliance Program Description; Structural Organization: Compliance Office, page 2.	Full	The requirement is addressed on page 2 of the Compliance Program Description.	
15.2	**Fraud and Abuse Compliance Program**				
15.2.1	In accordance with 42 CFR §438.608(a), the MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan	2016 ACLA Compliance Program Description 2016 ACLA CPD Exhibit 2 (161.100.001—PI Overview of	Full	The requirement is addressed through the Compliance Program Description document and Policy 161.100.001, which outlines the duties and responsibilities of the	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	Responsibilities)		plan's Program Integrity Department.	
15.2.2	In accordance with 42 CFR §438.605(b)(2), the MCO shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The MCO shall have an adequately staffed Medicaid Program Integrity Office with oversight by the Program Integrity Officer.	2016 ACLA Compliance Program Description; Structural Organization, pages 1-3.	Full	The Compliance Program Description outlines the organization of the plan's Compliance Office, including the responsibilities of the Director of Compliance and the Compliance Committee.	
15.2.3	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCMO shall submit updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	2016 ACLA Compliance Program Description; Overview, page 1.	Full	Page 1 of the Compliance Program Description addresses the requirement that the plan submit updates and modifications to LDH within 30 days of the effective date. Further, the plan provided evidence of email correspondence with LDH addressing the original submission of the Compliance Program Description to LDH for approval.	
15.2.3.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;	2016 ACLA Compliance Program Description; Program Elements: Written Standards of Conduct/Policies & Procedures, pages 3-4.	Full	The requirement is stated verbatim on page 3 of the Compliance Program Description.	
15.2.3.2	Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	2016 ACLA Compliance Program Description; Program Elements: Communications Systems, page 6; Auditing, Monitoring, Reporting & Remediation: Enforcement & Disciplinary Actions, page 7.	Full	The requirement is addressed on pages 6-7 of the Compliance Program Description.	
15.2.3.3	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Enforcement & Disciplinary	Full	The requirement is stated verbatim on page 6 of the Compliance Program Description.	

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Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	improvement activities, and provider activities;	Actions, page 6.			
15.2.3.4	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 Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;	2016 ACLA Compliance Program Description; Program Elements: Communications Systems, page 6.	Full	The requirement is addressed on page 6 of the Compliance Program Description.	
15.2.3.5	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation, page 6. 2016 ACLA Exhibit 2 (161.100.001—PI Overview of Responsibilities)	Full	The requirement is addressed on page 6 of the Compliance Program Description. In addition, the plan provided Policy 161.100.001 as evidence of internal procedures for monitoring and auditing fraud, waste, and abuse.	
15.2.3.6	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General.	2016 ACLA Compliance Program Description; Program Elements: Communications Systems, page 6; Auditing, Monitoring, Reporting & Remediation: Enforcement & Disciplinary Actions, page 6.	Full	Page 6 of the Compliance Program states "All associates are protected from any retaliation under the whistleblowers provision." Page 7 also addressed this requirement and states, in terms of retaliation, that "Violations may be reported to DHH or the U.S. Office of the Inspector General."	
15.2.3.7	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Response & Prevention, page 6.	Full	The requirement is addressed on page 6 of the Compliance Program Description.	
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Enforcement & Disciplinary Actions, page 6.	Full	Page 7 of the Compliance Program Description states that violations of the compliance program are enforced via the plan's Code of Conduct.	
15.2.3.9	Effective education for the Program Integrity Officer, program integrity investigators,	2016 ACLA Compliance Program Description; Program	Full	The Compliance Program Description states that "…all	

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	managers, employees, providers and members to ensure that they know and understand the provisions of MCO's compliance plan;	Elements: Education & Training, pages 4-5. ACFC FWA Training Module Screenshot (Full module available at: http://amerihealthcaritas.adobeconnect.com/entfwa/)		associates must complete ACFC's fraud, waste, and abuse training module…," and the plan provided the link to the online training module. The training module is in-depth and interactive.	
15.2.3.10	Fraud, Waste and Abuse Training shall include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.	2016 ACLA Compliance Program Description; Program Elements: Education & Training, pages 4-5. ACFC 2015 FWA Training Module	Full	Page 4 of the Compliance Program Description states "…all associates must complete ACFC's fraud, waste, and abuse training module, upon hire and annually thereafter."	
15.2.3.11	MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse • Procedures for timely consistent exchange of information and collaboration with DHH; • Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.	2016 ACLA Compliance Program Description; Program Elements: Education & Training, pages 4-5. ACFC 2015 Code of Ethics & Conduct Review & Attest: http://amerihealthcaritas.adobeconnect.com/codeofethicsconduct/ ACFC 2015 HIPAA Training: http://amerihealthcaritas.adobeconnect.com/hipaa2015/ ACFC 2015 Security Awareness Training: http://amerihealthcaritas.adobeconnect.com/securityawareness/ ACFC 2015 FWA training module: http://amerihealthcaritas.adobeconnect.com/entfwa/ ACLA New Hire Orientation PowerPoint ACFC 2015 Compliance Laws	Full	The Compliance Program Description outlines the plan's education and training for all employees. The plan also provided links to each of its training modules, which are interactive and in-depth. Additionally, the plan provided its New Hire Orientation PowerPoint, in which employees are educated on who the liaison between the plan and DHH is and are provided with contact information for that person.	

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		Training: http://amerihealthcaritas.adobeconnect.com/compliancelaws/			
15.3	**Prohibited Affiliations**				
15.3.1	In accordance with 42 CFR 438.610, the MCO is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.				
15.3.2	The MCO shall comply with all applicable provisions of 42 CFR 438.610 pertaining to debarment and/or suspension. The MCO shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 7.	Full	The requirement is addressed on pages 7-8 of the Compliance Program Description.	
15.3.3	The MCO shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); • Louisiana Adverse Actions List Search; • The System of Award Management (SAM); and • Other applicable sites as may be determined by DHH	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 8.	Full	The websites are listed on page 8 of the Compliance Program Description, with a statement that reads "This list is subject to change at DHH discretion."	
15.3.4	The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, pages 7-8.	Full	Page 8 of the Compliance Program Description states "No less than monthly, AmeriHealth Caritas Louisiana shall ensure that searches…are conducted for individuals…that have been excluded…" Page 8 also states that exclusion information will be reported to LDH immediately, but no later than 3 business days after discovery.	

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	the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).			Page 7 states that "excluded providers cannot bill or cause services to be billed to Medicaid. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded."	
15.3.4.1	An individual who is an affiliate of a person described above include: • A director, officer, or partner of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, pages 7-8.	Full	The requirement is stated verbatim on pages 7-8 of the Compliance Program Description.	
15.3.4.2	The MCO shall notify DHH within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 8.	Full	Page 8 of the Compliance Program Description states "ACLA will also report to LDH any criminal action under 42 CFR 1320 or 42 CFR 455.106 being taken against the plan or its affiliates…within 3 business days."	
15.4	**Payments to Excluded Providers**				
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services; and	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 7.	Full	The requirement is stated verbatim on page 7 of the Compliance Program Description.	
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation:	Full	The requirement is stated verbatim on page 7 of the Compliance Program Description.	

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		Sanction Screening & Background Checks, page 7.			
15.5	**Reporting**				
15.5.1	In accordance with 42 CFR 455.1(a)(1) and 455.17, the MCO shall be responsible for promptly reporting suspected fraud, abuse, waste, and neglect to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 USC 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	Page 10 of the Compliance Program Description states that the plan reports suspected fraud, abuse, waste, and neglect within 3 business days of discovery to LDH, takes prompt corrective actions, and cooperates with LDH. Page 8 of the Compliance Program Description states "ACLA will also report to LDH any criminal action under 42 CFR 1320 or 42 CFR 455.106 being taken against the plan or its affiliates…within 3 business days."	
15.5.2	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:				
15.5.2.1	Number of complaints of fraud, abuse, waste, neglect, and overpayments made to the MCO that warrant preliminary investigation (defined at 42 CFR 455.14);	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	The requirement is stated verbatim of page 10 of the Compliance Program Description.	
15.5.2.2	Number of complaints reported to the Program Integrity Officer; and	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 10.	Full	The requirement is stated verbatim of page 10 of the Compliance Program Description.	
15.5.2.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide DHH, at a minimum, the following: • Provider name and ID number; • Source of complaint; • Type of complaint; • Nature of complaint; • Approximate range of dollars involved if applicable; and • Legal and administrative disposition of the	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, pages 10-11.	Full	The requirement is stated verbatim of page 11 of the Compliance Program Description.	

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	case and any other information necessary to describe the activity regarding the complainant.				
15.5.3	The MCO, through its compliance officer, shall attest to DHH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation: Sanction Screening & Background Checks, page 8.	Full	The requirement is stated verbatim of page 8 of the Compliance Program Description.	
15.6	**Medical Records**				
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	2016 ACLA Compliance Program Description; Auditing, Monitoring, Reporting & Remediation, page 6. 2016 ACLA CPD Exhibit 2 (161.100.001-PI Overview of Responsibilities) Special Investigations Unit Member Service Verification, page 5. ACLA 205.005 (Medical & Treatment Record Review)	Full	Policy 106.100.001, page 5, provides a description of the process that SIU uses to validate members who received billed services. This section references Policy 106.100.013, which outlines the procedures for Member Services Verification. Additionally, the plan provided Policy 205.005, which outlines the procedures for Medical Record Review. The Provider Manual, page 26 states "Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate…," addressing the component of this requirement that calls for providers to maintain individual records for each member.	
15.6.1.1	Accurate and legible;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 5.	Full	The requirement is stated verbatim on page 5 of the provided document, #1. It is also stated on page 27 of the Provider Manual.	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	ACLA 205.005 (Medical & Treatment Record Review), Policy section, page 1.	Full	The requirement is stated verbatim on page 1 of the provided document. It is also stated on page 27 of the Provider Manual.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	ACLA 205.005 (Medical & Treatment Record Review), Policy section, page 1.	Full	The requirement is stated verbatim on page 1 of the provided document. It is also stated on page 27 of the Provider Manual.	

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15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	ACLA 205.005 (Medical & Treatment Record Review), Purpose section, page 2.	Full	The requirement is addressed on page 2 of the provided document. The policy states "Medical and treatment record Documentation Standards are outlined in Attachments A and C." These attachments were also provided.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex, and legal guardianship (if applicable);	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 5.	Full	The requirement is stated verbatim on page 5 of the provided document, #2. It is also stated on page 27 of the Provider Manual.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 5.	Full	The requirement is stated verbatim on page 5 of the provided document, #3. It is also stated on page 27 of the Provider Manual.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 5.	Full	The requirement is stated verbatim on page 5 of the provided document, #5. It is also stated on page 27 of the Provider Manual.	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 6.	Full	The requirement is stated verbatim on page 6 of the provided document, #6. It is also stated on page 27 of the Provider Manual.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 6.	Full	The requirement is stated verbatim on page 6 of the provided document, #7. It is also stated on page 27 of the Provider Manual.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 6.	Full	The requirement is stated verbatim on page 6 of the provided document, #8. It is also stated on page 27 of the Provider Manual.	
15.6.2.7	Signed and dated consent forms (as applicable);	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 7.	Full	The requirement is stated verbatim on page 7 of the provided document, #9. It is also stated on page 27 of the Provider Manual.	
15.6.2.8	Documentation of immunization status;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical	Full	The requirement is stated verbatim on page 7 of the provided document, #10. It is also stated on	

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		Record Review Standards, page 7.		page 27 of the Provider Manual.	
15.6.2.9	Documentation of advance directives, as appropriate;	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 7.	Full	The requirement is stated verbatim on page 7 of the provided document, #11. It is also stated on page 27 of the Provider Manual.	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint of purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and initials of providers must be identified with correlating signatures.	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 8.	Full	Page 8 of the document provided, #12, states all of the components of this requirement EXCEPT the credentials of the provider rendering the services. However, this component is addressed in the Provider Manual on page 27. Recommendation: While this requirement has been deemed "Full," the plan should include the missing component in Policy 205.005.	
15.6.2.11	Documentation of EPSFT requirements including but not limited to: Comprehensive health history; Unclothed physical exam; Vision, hearing, and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	ACLA 205.005 (Medical & Treatment Record Review), Attachment A—Medical Record Review Standards, page 8.	Full	The requirement is stated verbatim on page 8 of the provided document, #13. It is also stated on page 27 of the Provider Manual.	
15.6.3	The MCO is required to provide one (1) free copy of any part of a member's record upon member's request.	ACLA 124.12.019 (Member Rights & Responsibilities), Members' Rights, page 4.	Full	The requirement is addressed on page 4 of Policy 124.12.019.	
15.6.4	All documentation and/or records maintained by the MCO or any and all of its network providers shall be maintained for at least six (6) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	ACLA Provider Handbook: PCP & Specialist Medical Record Requirements, pages 27-28. ACFC 168.114 (Records Retention), Attachment A, page 7.	Full	Page 27-28 of the Provider Handbook states "Providers must maintain medical records for a period not less than 10 years from the close of the Network Provider Agreement and retained further if the records are under review or audit until the audit or review is complete." Further, the plan established a Retention Schedule via Policy No. 168.114, which outlines the time frames for retaining records.	

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				However, the provided documentation does not specify when the 10 year retention period begins, except for the close of the Network Provider Agreement. Recommendation: The plan should clarify when the 10 year retention period begins within the above policy.	
15.7	**Rights of Review and Recovery by MCO and DHH**				
15.7.1	Each MCO is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the MCO subcontracts to outside entities.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Investigations, page 12.	Full	The requirement is addressed on page 12 of the Compliance Program Description.	
12.5.2	The MCO has the exclusive right of review and recovery for 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment by delivering such notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Complex Reviews, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
15.7.3	All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the Department. This review period is inclusive of all provider notification, health plan document review, and including any provider appeal or rebuttal process. The MCO shall notify the Department, at least on a monthly	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Complex Reviews, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	

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	basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.				
15.7.4	The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Complex Reviews, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
15.7.5	If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim review recovery after 365 days from the date of notice to the Department of the collection status, unless in either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Complex Reviews, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
15.7.6	The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of an improper payment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Automated Reviews, page 14.	Full	The requirement is addressed on page 14 of the Compliance Program Description.	
15.7.7	DHH may recover from the provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries; Automated Reviews, page 14.	Full	The requirement is stated verbatim on page 14 of the Compliance Program Description.	
15.7.8	DHH must notify the MCO of an identified	2016 ACLA Compliance	Full	The requirement is addressed on	

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	improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payment(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.	Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries, page 13.		page 13 of the Compliance Program Description.	
15.7.9	The MCO shall not correct claims not initiate an audit on the claims upon notification by the Department or its agent unless directed to do so by the Department.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
15.7.10	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department of its agent will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund any amounts collected to the Department. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
15.7.11	There will be no DHH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Bayou Health Contract period of for providers for which no MCO relationship existed.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Prohibitions: Recoveries, page 13.	Full	The requirement is addressed on page 13 of the Compliance Program Description.	
	Additional PE-Related RFP Sections				
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description.	

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	12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.				
4.1.4	The MCO shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description.	
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting, page 11.	Full	The requirement is addressed on page 11 of the Compliance Program Description.	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description.	

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	Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.				
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description.	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, pages 7-8.	Full	The requirement is addressed on pages 7-8 of the Compliance Program Description.	
17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description.	
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8. 170 ACLA 2015 (Ownership Disclosure) 20160330 Submission	Full	Page 7 of the Compliance Program Description states "All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this contract shall submit routine disclosures… at initial contracting, contract renewal, within 35 days of change, at least once annually, and at any time, upon request."	

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				The documentation provided (170 ACLA 2015) was an example of email correspondence showing submission of the document.	
18.2	**Information Related to Business Transactions-** 18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Information Related to Business Transactions, page 11.	Full	The requirement is addressed on page 11 of the Compliance Program Description.	
18.3	**Report of Transactions with Parties in Interest–** 18.3.1 The MCO shall report to DHH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.	2016 ACLA Compliance Program Description; Fraud, Waste & Abuse: Notifications & Reporting; Report of Transactions with Parties in Interest, page 11.	Full	The requirement is addressed on page 11 of the Compliance Program Description.	

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	18.3.2 Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest. 18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.				
18.7	The MCO shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, page 8.	Full	The requirement is addressed on page 8 of the Compliance Program Description: "ACLA will also report to DHH any criminal action under 42 CFR 1320 or 42 CFR 455.106 being taken against the plan or its affiliates…"	
24.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the	2016 ACLA Compliance Program Description; Sanction Screening & Background Checks, pages 7-8.	Full	The requirement is addressed on pages 7-8 of the Compliance Program Description.	

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	Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp; the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.dhh.la.gov/; and/or the System for Award Management, http://www.sam.gov . 25.13.2 The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).				
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual; Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care	2016 ACLA Compliance Program Description; Fraud, Waste, & Abuse: Prohibitions, page 12.	Full	The requirement is addressed on page 12 of the Compliance Program Description.	

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	services unless the MCO provides the appropriate surety bond.				