Contract RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Titles(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
10.1					
10.1	The MCO shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their MCO network, This function shall:	Met The policy states that the Plan offers a Provider Services function to address non-emergent and emergent provider issues.	124.12.013 Contact Center Scope (Provider Services)	Policy	Page 1
10.1.1	Be available Monday through Friday from 7 am to 7 pm Central Time to address non-emergency provider issues and on a 24/7 basis for non-routine prior authorization requests;	Met The policy states that Provider Services is available 7am-7pm CST Monday-Friday and 24/7 for emergent and non-routine prior authorizations.	124.12.013 Contact Center Scope (Provider Services)	Policy	Page 1
10.1.2	Assure each MCO provider is provided all rights outlined the Provider's Bill of Rights (see Appendix R);	Met The Provider's Bill of Rights is addressed in the provider manual.	ACLA Provider Handbook	Provider's Bill of Rights	Pages 83-84
10.1.3	Provide for arrangements to handle emergent provider issues on a 24/7 basis;	Met The policy states that Provider Services is available 24/7 for emergent and non-routine prior authorizations.	124.12.013 Contact Center Scope (Provider Services)	Policy	Page 1
10.1.4	Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and	Met The document addresses the requirement.	ACLA Network Development & Management Plan 2015 (See 7.1) PNM Provider Visit Requirements_12162014	Network Resources & Provider Support	Pages 15-18
10.1.5	Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.	Met The policy details the provider visit schedule (hospital = one visit per quarter, integrated delivery system = one visit per quarter, PCP with < 500 members = one visit per quarter, PCP with > 500 members = one visit per month, specialist = one visit annually, ancillary = one visit annually).	159.800 Provider Visit Requirements	Procedure	Page 2
10.2					
10.2.1	The MCO must operate a toll-free telephone line to respond to provider questions, comments and inquiries.	Met Provider Services has a toll free number (888-922-0007) for provider inquiries.	124.12.013 Contact Center Scope (Provider Services) (See 10.1)	Procedure	Page 3
10.2.2	The provider access component of the toll-free telephone line must be staffed between the hours of 7am -7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.	Met The policy states that Provider Services is available 7am-7pm CST Monday-Friday and 24/7 for emergent, non-routine prior authorizations and staffed on a 24/7 basis for prior authorization requests..	124.12.013 Contact Center Scope (Provider Services) (See 10.1)	Procedure	Page 3
10.2.3	The MCO's call center system must have the capability to track provider call management metrics.	Met The Plan tracks provider call management metrics including individual goals (real time adherence, total average handle time, off the phone time) and department goals (average speed of answer, abandon rate, answer 90% of calls within 30 seconds or an automatic pickup system).	124.12.013 Contact Center Scope (Provider Services) 124.12.014 - Contact Center Telephone System	Monitoring for performance	Page 4

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10.2.4	After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any MCO member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency department services and care.	Met The policy states "After normal business hours, there are messages regarding normal business hours and instructions to verify enrollment for any Amerihealth Caritas Louisiana member with an emergency or urgent medical condition.	124.12.013 Contact Center Scope (Provider Services)	Procedure: Phone lines and Services	Page 3
10.3					
10.3.1	The MCO shall have a provider website. The provider website may be developed on a page within the MCO's existing website (such as a portal) to meet these requirements.	Met The print screen provided by the Plan shows the website available to the Plan's providers.	Print Screen of Provider Website	Website print screen	Full document
10.3.2	The MCO provider website shall include general and up-to-date information about the MCO as it relates to the Louisiana Medicaid program. This shall include, but is not limited to: 10.3.2.1. MCO provider manual; 10.3.2.2. MCO-relevant DHH bulletins; 10.3.2.3. Limitations on provider marketing; 10.3.2.4. Information on upcoming provider trainings; 10.3.2.5. A copy of the provider training manual; 10.3.2.6. Information on the provider grievance system; 10.3.2.7. Information on obtaining prior authorization and referrals; and 10.3.2.8. Information on how to contact the MCO Provider Relations.	Met The print screen displays all of the resources available to the provider and meet the requirements.	Print Screen of Provider Website	Website print screen	Full document
10.3.3	The MCO provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) days of the date the MCO signs the Contract.	N/A: As an incumbent, the plan has met this requirement.	161.001 Creation & Approval of Communications Material	Full document	Full document
10.3.4	The MCO must notify DHH when the provider website is in place.	N/A: As an incumbent, the plan has met this requirement.	N/A – Does not apply to existing plans; provider website is already in place.		
10.3.5	The MCO must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.	Met The EHNAC website shows HIPAA Compliance for Navinet as of 11/14.	Navinet, our provider portal housing member eligibility and identification information, has their HIPAA Compliance certified during EHNAC accreditation. Evidence located at: https://www.ehnac.org/accreditation-		

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			full/		
10.3.6	The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.	Met The print screen provided by the Plan includes a certificate of compliance with Section 508 of the ADA via the plan's vendor.	ADA Compliance Certificate		
10.4					
10.4.1	The MCO shall develop and issue a provider handbook within thirty (30) days of the date the MCO signs the Contract with DHH. The MCO may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the MCO's website. This notification shall also detail how the provider can request a hard copy from the MCO at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding MCO covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all MCO requirements are met. At a minimum, the provider handbook shall include the following information:	Met As an incumbent plan, ACLA has an existing approved provider Handbook.	ACLA Provider Handbook		
10.4.1.1	Description of the MCO;	Met The Provider Handbook provides a description of the Plan.	ACLA Provider Handbook	About Amerihealth Caritas Louisiana	Page 9
10.4.1.2	Core benefits and services the MCO must provide;	Met Core services are discussed in detail in the Provider Handbook.	ACLA Provider Handbook	Covered Services	Pages 33-34
10.4.1.3	Emergency service responsibilities;	Met Emergency services are discussed in detail in the Provider Handbook.	ACLA Provider Handbook	ER Medical Care	Pages 36-41
10.4.1.4	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the MCO to file a provider complaint, the timeframes allowed for resolving claims payment issues and the process a provider would take to escalate unresolved issues;	Met The Provider complaint system is discussed in detail in the Provider Handbook.	ACLA Provider Handbook	Provider Complaints and Claim Disputes	Pages 84-87
10.4.1.5	Information about the MCO's Grievance System, that with written permission from the member, the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's	Met Grievance System procedures are discussed in detail in the Provider Handbook.	ACLA Provider Handbook	Member Grievance and Appeal Process	Pages 125-127

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	right to request continuation of services while undergoing due process in the MCO's appeal process, and any additional information specified in 42 CFR §438.10(g)(1). The member's written approval may be obtained in advance as part of the member intake process.				
10.4.1.6	Medical necessity standards as defined by DHH and practice guidelines;	Met Medically Necessary Services are discussed in detail in the Provider Handbook.	ACLA Provider Handbook	Medically Necessary Services	Pages 32-33
10.4.1.7	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Met The Plan's Complex Care Management program is discussed in the Provider Handbook.	ACLA Provider Handbook	Complex Care Management	Pages 112-113
10.4.1.8	PCP responsibilities;	Met The PCP's Responsibilities are discussed in the Provider Handbook	ACLA Provider Handbook	Your Role As PCP Provider Responsibilities	Page 11 Pages 11-12
10.4.1.9	Other provider responsibilities under the subcontract with the MCO;	Met The provider's other Responsibilities are discussed in the Provider Handbook	ACLA Provider Handbook	Additional PCP Responsibilities	Pages 12-14
10.4.1.10	Prior authorization and referral procedures;	Met Prior authorization and referrals are discussed in the Provider Handbook	ACLA Provider Handbook	Referrals, Prior Authorization Requirements	Pages 30-32
10.4.1.11	Medical records standards;	Met Medical record standards are discussed in the Provider Handbook	ACLA Provider Handbook	PCP and Specialist Medical Record Requirements	Pages 21-22
10.4.1.12	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;	Met Claims submission protocols and standards are discussed in the Provider Handbook	ACLA Provider Handbook	Procedure for Claim Submission	Pages 67-71
10.4.1.13	MCO prompt pay requirements (see Section § 9);	Met The Plan's prompt pay requirements are discussed in the Provider Handbook	ACLA Provider Handbook	Procedure for Claim Submission	Page 71
10.4.1.14	The MCO's chronic care management program;	Met The Plan's Complex Care Management program (including Diabetes, COPD, Asthma, Sickle Cell, Obesity and Cardiovascular Disease) is discussed in the Provider Handbook	ACLA Provider Handbook	Complex Care Management	Pages 112-113
10.4.1.15	Quality performance requirements; and	Met The Plan's Quality Management program is discussed in the Provider Handbook	ACLA Provider Handbook	Quality Management	Pages 99-101
10.4.1.16	Provider rights and responsibilities.	Met The Provider's Rights and Responsibilities are discussed in the Provider Handbook	ACLA Provider Handbook	Provider Bill of Rights	Pages 83-84
10.4.2	The MCO shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Met The Provider Handbook states that "announcements and new bulletins will also be posted on www.amerihealthcaritasla.com".	ACLA Provider Handbook	Additional Resources	Page 136
10.4.3	The MCO shall make available to DHH for approval a provider handbook specific to the Louisiana MCO Program,	Met	161.001 Creation & Approval of Communications Material	Full document	Full document

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	no later than thirty (30) days prior from the date the MCO signs the Contract with DHH.	The document describes the review and approval process for all forms of communication that require approval including the Provider Handbook.			
10.5					
10.5.1	The MCO shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The MCO shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The MCO shall also conduct ongoing training, as deemed necessary by the MCO or DHH, in order to ensure compliance with program standards and the Contract.	Met The documents address provider support, initial orientation & training (within 30 days of completing the Plan's credentialing process), review of the Provider Manual, Provider Claims Training and Future Training and Ongoing Provider Support.	Network Management Training Outline Hospice Provider Development & Training Plan EPDST-PCS Provider Development & Training Plan	Full document Full document Full document	Full document Full document Full document
10.5.2	The MCO shall submit a copy of the Provider Training Manual and training schedule to DHH for approval within thirty (30) calendar days of the date the MCO signs the Contract with DHH. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.	Met The documentation discusses the review and approval process for all forms of communication that require approval including the Provider Training Manual.	161.001 Creation & Approval of Communications Material	Full document	Full document
10.5.3	The MCO shall develop and offer specialized initial and ongoing training in the areas including but not limited to billing procedures and service authorization requirements for network providers who have traditionally billed and obtained service authorization primarily from Medicaid and/or Medicare only. This includes but is not limited to personal care services providers and hospice providers and may include other provider types at the discretion of DHH.	Met The documents address provider support, initial orientation & training (within 30 days of completing the Plan's credentialing process), review of the Provider Manual, Provider Claims Training and Future Training and Ongoing Provider Support.	Network Management Training Outline Hospice Provider Development & Training Plan EPDST-PCS Provider Development & Training Plan	Full document Full document Full document	Full document Full document Full document
10.6					

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10.6.1 10.6.1.1 10.6.1.2	Applicable Definitions Definition of Provider Complaint For the purposes of this subsection, a provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the MCO, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Definition of Action For the purposes of this subsection an action is defined as: The denial or limited authorization of a requested service, include the type or level of service; or the reduction, suspension, or termination of a previously authorized service; or the failure to provide services in a timely manner, as defined in Section §7.3 and Section §7.5 of this RFP; or the failure of the MCO to act within the timeframes provided in Section §13.7.1 of this RFP.	Met This requirement is addressed in the Provider Complaint and Dispute Policy.	170.005 - Provider Complaint and Dispute Processing and Resolution	Definitions	Page 1
10.6.2	The MCO shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	Met The document provides a detailed description of the Provider Complaint and Dispute Processing and Resolution process/	170.005 – Provider Complaint Dispute Processing and Resolution Provider Complaint System - EXP Flow	Full document	Full document
10.6.3	This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	Met The policy states that complaints can be received by phone, in writing or in person.	170.005 – Provider Complaint Dispute Processing and Resolution Provider Complaint System - EXP Flow	Complaints	Page 3
10.6.4	As part of the Provider Complaint system, the MCO shall:				
10.6.4.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	Met The document provided addresses this requirement.	170.005 – Provider Complaint Dispute Processing and Resolution	Complaints	Page 3
10.6.4.2	Identify a key staff person specifically designated to receive and process provider complaints;	Met Provider complaints are reviewed by a Provider Network Management Account Executive. If a provider is not satisfied with the initial decision, the complaint will be reviewed by the Second Level Dispute Committee.	170.005 – Provider Complaint Dispute Processing and Resolution	Complaints	Pages 3-4

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10.6.4.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures; and	Met The policy discusses the Plan's research and investigation process.	170.005 – Provider Complaint Dispute Processing and Resolution	Workflow, Research & Analysis	Pages 5-6
10.6.4.4	Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process, provide names, phone numbers and email addresses to DHH within one (1) week of contract approval and within two (2) business days of any changes.	Met Contact information for the key members of the Provider Complaint process is provided in the document.	170.005 – Provider Complaint Dispute Processing and Resolution	Provider Escalation Process	Page 5
10.6.5	The MCO shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The MCO shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed. Note that provider complaints must be acknowledged within 3 business days. They should be resolved as soon as feasible, but within no more than 30 calendar days; unless both the provider and DHH has been notified of the outstanding issues, including a timeline for resolution and reason for the extension of time. All complaints should be resolved in no more that 90 days. The policies and procedures shall include, at a minimum:	Met The document provides a detailed description of the Plan's Provider Complaint System. A determination of first level disputes will be made within 30 days of receipt. Any disputes pending over 30 days must be reported to DHH with an explanation as to why the dispute is pending. If the complaint is reviewed in the Arbitration process, a final decision must be rendered within 90 days. The documentation also includes the requirement to acknowledge provider complaints within 3 business days.	170.005 – Provider Complaint Dispute Processing and Resolution	Timeframes	Pages 3-4
10.6.5.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the MCO and the resolution time;	Met The document states that "First-level Claim Disputes must be received within 90 calendar days of the remittance advice or denial". The document discusses the process for filing a claim and resolution time frames.	170.005 – Provider Complaint Dispute Processing and Resolution	II. Timeframes	Page 3, Full Document
10.6.5.2	A description of how and under what circumstances providers are advised that they may file a complaint with the MCO for issues that are MCO Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the MCO;	Met The document provides examples of reasons why a provider may file a complaint including dissatisfaction with a policy, procedure or administrative function. Also, the provider is entitled to an Arbitration Hearing if they are not satisfied with the Plan's decision. The provider is not entitled to a State Fair Hearing for claims issues.	170.005 – Provider Complaint Dispute Processing and Resolution	Definition: Provider Complaint Arbitration	Page 1-2 Page 4
10.6.5.3	A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;	Met This requirement is addressed in the Provider Complaint Dispute Processing and Resolution documents. The Online Help Excerpt, which is the plan's reference system for provider relations staff) addresses this requirement.	170.005 – Provider Complaint Dispute Processing and Resolution	Procedure	Page 3

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10.6.5.4	A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	Met The document states "If several claims are impacted by the same issue, the provider may submit the dispute via the claim project spreadsheet".	170.005 – Provider Complaint Dispute Processing and Resolution	Procedure	Page 3
10.6.5.5	A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.	Met The document addresses the review and investigation process by the Plan's staff.	170.005 – Provider Complaint Dispute Processing and Resolution	Research & Analysis	Pages 5-6
10.6.5.6	A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	Met Contact information for the key members of the Provider Complaint process is provided in the document. Also, first level complaints are reviewed by Research Analysts. If the provider is not satisfied with the initial decision, the complaint is elevated to a Second Level complaint which is reviewed by the Second Level Dispute Committee (the policy defines the members of the committee).	170.005 – Provider Complaint Dispute Processing and Resolution	Provider Escalation Process Workflow	Page 5 Pages 5-8
10.6.5.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Met The document states "Network providers may request an on-site meeting wit a Network Management Account Executive, either at the provider's office or at ACLA to discuss the complaint".	170.005 – Provider Complaint Dispute Processing and Resolution	Resolution	Page 4.
10.6.5.8	Identification of specific individuals who have authority to administer the provider complaint process;	Met The document addresses the groups that can resolve a complaint/dispute (Provider Services, Second Level Dispute Committee and the Arbitration process).	170.005 – Provider Complaint Dispute Processing and Resolution		
10.6.5.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	Met The policy states that "Provider Complaints/Disputes will be captured and tracked whether received by telephone, in person or in writing".	170.005 – Provider Complaint Dispute Processing and Resolution	Reporting	Page 5
10.6.5.10	A provision requiring the MCO to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	Met The policy states that the Plan will "report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH".	170.005 – Provider Complaint Dispute Processing and Resolution	Reporting	Page 5
10.6.6	The MCO shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the MCOs Provider Relations staff; and contact information for the person from the MCO who receives and processes provider complaints.	Met The Provider complain system is discussed in detail in the Provider Handbook.	ACLA Provider Handbook	Provider Complaints and Claim Disputes	Pages 84-87
10.6.7	The MCO shall distribute the MCO's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice (RA). The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full	Met This requirement is addressed on page 38 of the Provider Orientation documentation.	170.005 – Provider Complaint Dispute Processing and Resolution		

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	policies and procedures on the MCO's website. This summary shall also detail how the in-network provider can request a hard copy from the MCO at no charge to the provider.				