AmeriHealth Caritas Louisiana

Provider Quality Monitoring Plan

All MCOs shall collaborate to develop and implement a plan for monitoring a statistically significant sample of specialized behavioral health providers and facilities across service categories, which incorporates onsite reviews and member interviews, on a quarterly basis. The MCOs shall submit the plan to LDH for approval no later than sixty (60) Calendar Days prior to any Material Change. The MCO's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the MCO Manual.

RFP Reference: Quality Monitoring Reviews 2.16.22

The MCOs shall collaborate with each other to develop and implement a plan for monitoring specialized behavioral health (SBH) providers and facilities across all levels of care, which incorporates onsite reviews and enrollee interviews, with a focus on unlicensed providers delivering care. The MCO shall conduct quality monitoring reviews on a sample of providers on a quarterly basis. The MCO shall submit the plan to LDH for approval within 60 calendar days after the operational start date and at least 60 calendar days prior to material change. The MCO's plan shall comply with all the requirements as specified by LDH:

- **Review criteria for each applicable service which evaluates if the assessment and treatment are conducted timely and include member participation, the quality of the assessment and treatment plan, whether members are receiving services as reflected in the treatment/service plan, clinical practice guideline adherence, patient safety including adverse incident management/reporting, care coordination, discharge planning as applicable, enrollee rights and confidentiality;**
- **Plan for updating review criteria based on changes to requirements as reflected in the applicable provider manual or rule;**
- **Number of charts to be reviewed at each provider location (the MCO shall review a reasonable number of records to determine each provider's compliance rate) and look-back period;**
- **Enrollee interview criteria, including target number of enrollees to be interviewed and survey questions, to evaluate quality of care, satisfaction, receipt of service, and enrollee outcomes;**
- **Onsite review criteria;**
- **Sample selection criteria, including inclusion and exclusion criteria, and representative sample size;**
- **Tools to be used and weight of each review element;**
- **Qualifications for staff performing monitoring reviews who at a minimum must be an LMHP or psychiatrist unless otherwise approved by LDH;**

- **Plan for educating providers on the provider monitoring process, including review criteria and corrective actions, initially and ongoing;**
- **Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;**
- **Plan for ensuring corrective actions are implemented appropriately and timely by providers; and**
- **Inter-rater reliability testing methods, including targets, processes to ensure staff participate in reliability testing reviews initially and at least annually, and processes to ensure staff meet the target rate prior to conducting reviews independently.**

The sample size may be increased at the discretion of LDH. LDH reserves the right to select the MCO's sample.

The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state requirements. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.

The MCO shall submit routine reports using the template provided by LDH which summarize monitoring activities, findings, corrective actions, and improvements for SBH services.

For desktop reviews, the MCO shall maintain documentation used to determine the providers' compliance for a minimum of three years from the date of review.

MCO Manual Version 3.0 Reference, Part 13, p. 232: Quality Monitoring Reviews for Behavioral Health Providers

Quality Monitoring Reviews for Behavioral Health Providers

Professional Standards of Practice Observed

It is the policy of the MCOs to measure compliance with Behavioral Health Provider Monitoring Standards and standards as outlined by the National Commission of Quality Assurance. The Behavioral Health Provider Monitoring Process of the MCOs will endeavor to facilitate appropriate utilization of health care resources for members through review, analysis, and evaluation of documentation and record keeping practices provided by Behavioral Health Service Providers included in the care of the member to ensure compliance with established state and federal guidelines and regulations. SBHS

providers sampled must meet 80% overall to be deemed passing or be subject to a corrective action plan. Treatment records are to be maintained in a manner that is current, detailed, organized, and which permits effective and confidential member care as well as quality review. Treatment records must be maintained as an individual health record for each member. The Provider Quality Monitoring Review criteria will include the following, but is not limited to: adherence to clinical practice guidelines; adherence to agency specific clinical documentation requirements, enrollee rights and confidentiality, including advance directives and informed consents; cultural competency; patient safety including adverse incident management/reporting; appropriate use of restraints and seclusions; treatment planning components (evaluates if the assessment and treatment are conducted timely and include member participation, the quality of the assessment and treatment plan, whether members are receiving services as reflected in the treatment/service plan); adequate discharge planning, as applicable; and care coordination. Treatment Records should reflect all services provided directly by the LMHP, physician, specialist, and any other practitioners, including non-licensed staff, and should include ancillary services and diagnostic tests ordered by the practitioner, and the diagnostic and therapeutic services for which the practitioner referred the member.

The MCOs, in compliance with the Health Insurance Portability and Accountability (HIPPA) Privacy Rule (45 C.F.R. § 164.530(i), develop and implement this written policy and procedure to protect members protected health information (PHI). This policy establishes and implements a process for treatment record requests that limit the use and disclosure of PHI to that which is the minimum amount reasonably necessary to achieve the intended purpose of the use, disclosure, or request. (Refer to 45 C.F.R. §§ 164.502(b) and 164.514 (d.) Member's treatment records must be treated as confidential information and accessible only to authorized persons. Treatment records for all members evaluated or treated should be safeguarded against loss, destruction, or unauthorized use, maintained in an organized fashion, and readily accessible and/or available for review and audit to comply with company standards, provider specific contracts, and in accordance with Louisiana Revised Statue § 40:1165.1 (2015).

The MCOs establish policies and procedures, performance measures, and goals to evaluate treatment record keeping practices and addresses confidentiality, maintenance, and availability of quality treatment records through provider contracts accessible to appropriate staff. Each MCO will conduct meetings as needed to review results and address any identified issues and/or concerns that may potentially require additional referrals.

MCO employees completing reviews

- **Employees who can complete reviews are:**
    - **LMHPs as defined in the BHS Provider Manual:**
        - **Medical psychologists**
        - **Licensed psychologists**

- **Licensed Clinical Social Workers (LCSWs)**
- **Licensed Professional Counselors (LPCs)**
- **Licensed Marriage and Family Therapists (LMFTs)**
- **Licensed Addiction Counselors (LACS)**
- **APRNs (must be a nurse practitioner (NP) specialist in adult psychiatric and mental health, and family psychiatric and mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health, and may practice to the extent that services are within the APRN's scope of practice)**

- **Psychiatric Nurses**

Staff Training

Each MCO conducts ongoing staff training and education on identified trends, best practices, and opportunities for improvement.

Tools Utilized

The MCOs will utilize the following tools for the review process:

- **Behavioral Health Provider Quality Monitoring Tool Clinical Elements (Attachment A).**
  - **Clinical Elements are available for providers to review in the following locations:**
    - **Aetna:** https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/louisiana/providers/pdf/abh_176_mco_bh_pqmp_2022_scoring%20_grid.pdf
    - **AmeriHealth Caritas:** https://www.amerihealthcaritasla.com/pdf/provider/behavioral-health/behavioral-health-provider-quality-monitoring-tool-elements.pdf
    - **HealthyBlue:** https://provider.healthybluela.com/dam/publicdocuments/LA_CAID_BehavioralHealthProviderQualityMonitoringToolElements.pdf
    - **Humana:** https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4968132 [docushare-web.apps.external.pioneer.humana.com]
    - **Louisiana HealthCare Connections:** BH - Provider Quality Monitoring Tool (louisianahealthconnect.com)
    - **United Healthcare:** https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wLA.html

- **Behavioral Health Provider Quality Monitoring Scoring Grid utilized by all MCOs**
- **Provider Quality Monitoring Review Scorecard**
- **Clinical Practice Guidelines Checklist as developed per each individual MCO**.
- **Notification of Deficiencies Letter**
- **Corrective Action Plan Template specific to each individual MCO.**

Tools will be reviewed by the MCOs at minimum on an annual basis but not more than quarterly to make any needed changes.

Inter-rater reliability
At minimum the MCOs ensure all designated reviewers complete Inter-rater reliability testing across MCOs initially and at least annually and implement processes to ensure staff meet the target rate prior to conducting reviews independently. Each MCO will contribute the treatment plan and progress notes from one redacted member record received for monitoring previously for use in the interrater process resulting in a total of six (6) redacted records for use in the all MCO IRR audit. The IRR audit passing score is 90% and is operationally defined as follows: each individual element has a value (correct response or not); those individual elements are totaled up (number of correct responses or not in comparison to standardized record); and overall score is obtained. Failure to meet a 90% for IRR will result in the designated reviewer being referred for remediation according to the individual MCO processes. The reviewer will not be able to independently review records until a score of 90% is reached.

All MCO IRR Process

1. **Each MCO will provide redacted record (1) consisting of only treatment plan and progress notes**
2. **Each MCO key rep on Quality subcommittee to score records for standardization**
3. **Once records standardized, the records will be kept on repository for future use at each MCO**
    a. **All six (6) standardized records will be sent and stored to each MCO via key representative.**
    b. **Each MCO will score their own designated reviewers utilizing one (1) standardized record per designated reviewer to complete an IRR audit.**
        i. **In the event, that the designated reviewer scores 89%-8~~7~~0%[KF1], MCO will utilize a second standardized record to complete a second IRR audit as a "second" chance record.**
    c. **Should a designated reviewer fail to meet 90%, that reviewer will be referred for remediation and further training until they achieve a 90% or better.**
4. **Trends identified from the annual IRR audit results will be addressed via training completed by the MCO Quality Subcommittee.**
    a. **The IRR audit would occur in Q2 for MCOs annually.**
        i. **For new hires, IRR audits would occur prior to them completing their**

first review independently.

b. Training for all MCO designated reviewers will be tailored to the results of the IRR audit.

Provider Type reviewed

Provider types reviewed will include:

- Mental Health Outpatient providers/practitioners
  - Individual/Group Practice (Psychiatrist, Psychologist, LPC, LMFT, LCSW, LAC, APRN)
  - MHR Agencies,
  - Other agency types (LGE, FQHC, RHC, Group Outpatient), and
  - Other outpatient provider types such as peer support specialists, crisis resource service providers, personal care services).
- Substance Use Outpatient
  - Opioid Treatment Providers (OTPs)
  - All Substance Use Treatment Outpatient Providers – Individual/Group Practice LACs and ASAM Levels 1, 2.1, and 2-WM
- Residential
  - Therapeutic Group Homes (TGH)
  - Psychiatric Residential Treatment Facilities (PRTF)
  - Residential Substance Use Treatment

***ACT, MST, FFT, FFT-CW, and Homebuilders are excluded providers from the quality monitoring due to separate fidelity reviews.**

Frequency of Reviews

The Provider Monitoring process is continuous throughout the year. The MCOs will ensure providers are not reviewed more than once within a 12-month period unless the MCO identifies cause for a re-review by sharing a list of eligible providers with the other MCOs. Eligible providers are those who have not been reviewed by MCOs within the calendar year and who have at least 5 unique members with at least 3 claims each, billed from two quarters immediately preceding the review quarter. Ineligible providers are those who pass their review with a score of 90% or greater, the provider will not be reviewed by any MCO within 24 months from the date of the review in which they passed and providers who may be under investigation with SIU. If the provider remains unresolved with the MCO's SIU team for more than 1 year from the date of the accepted date of referral made to the SIU team, then the provider must be placed back into the eligible list for quality monitoring.

The MCO Sub-committee will consolidate the eligible provider lists to de-duplicate providers. MCOs will have assigned regions to review within each quarter (see table

below). Exception will be made for a provider placed on the priority list by OBH/LDH to the MCO quality subcommittee. Priority review would occur within the same quarter requests from OBH/LDH is made, i.e., if request by OBH/LDH is made in Q2 of 2024, then MCOs would identify who would take priority review and attempt completion of review within Q2 of 2024. MCOs can refer providers to the priority list via LA358 to OBH/LDH, i.e., if a provider was due for a re-review and did not have claims for re-review to be completed, MCO would make note on the LA358 for this provider to be placed on Priority List. LDH/OBH will notify MCO Quality Subcommittee via Priority List requiring priority reviews. The MCO Quality Subcommittee would identify which MCO is 1.) Contracted with the provider and 2.) has identified claims with the provider to complete a priority review. Review would be initiated during the quarter that LDH/OBH notified MCO Quality Subcommittee of priority status. The MCO assigned the provider from the priority list will report on this provider on Table 6 of the LA358 report. If unable to review during that quarter, MCO would include on LA358 with rationale why review is not completed on table 6 and/or in narrative. Additionally, if there is a provider on the priority list that is on your MCO SIU list, that MCO cannot assign themselves to that provider on the priority list. Another MCO must be assigned the provider. For example, if ABC Therapy is under investigation for MCO 1, then MCO 1 will identify them as not having claims. One of the other MCOs will be assigned, if contracted and with identified claims.

	Q1	Q2	Q3	Q4
Regions	**6, 7, 8**	**3, 4, 5**	**1, 10**	**2, 9**

MCO Master List Assignment Schedule:

2023 Q1	**UHC**
2023 Q2	**ACLA**
2023 Q3	**AETNA**
2023 Q4	**Healthy Blue**
2024 Q1	**Humana**
2024 Q2	**LHCC**
2024 Q3	**UHC**
2024 Q4	**ACLA**
2025 Q1	**AETNA**
2025 Q2	**Healthy Blue**
2025 Q3	**Humana**
2025 Q4	**LHCC**

Sampling Approach

At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The

sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and residential. Additional levels of care may be added at the discretion of LDH. The statistical significance will be based on the total numbers from the collaborative pool identified as eligible providers by the MCOs. For instance, the combined MCO list totals 100 providers. After removing the ineligible providers (reviewed within 12 months, under SIU, etc.), the total number of providers shared across MCOs is 80. The list of 80 providers is deduplicated and used to determine statistically significant representative sample size for the review quarter, and each MCO will be assigned providers for review. Assignment considers the MCO with the most claims for any given provider. Assignments shall be distributed across the MCOs in a manner that is fair and equitable.

The MCOs will utilize a random sample generator for unique member selection based off claims and/or authorizations identified during the 6-month period prior to the review quarter. In addition to the providers identified by the random sample, any providers who were involved in Adverse Incidents and/or Quality of Care investigations may be added to the sample pool for quality monitoring review (if not already part of the generated sample).

Providers selected may not be available to review if they have an active case with the Special Investigation Unit (SIU), have already been reviewed within the calendar year, or have scored at least 90% or greater on recent review and has not yet been 24 months since that date of review, thus impacting the total number of reviews completed for the quarter.

Records Audited
A reasonable number of records at each site shall be reviewed to determine compliance. A minimum of five (5) records per site will be reviewed. An exception may occur and less records reviewed if a selected provider has seen fewer than five (5) MCO members.

Time Frame for Monitoring and Reporting
Initial review request, via email, postal letter, and/or phone call is made, and the provider is given 14 days to respond and/or schedule the review. If ACLA receives no response within the time frame allotted, the provider will be referred to the Interdepartmental Committee to determine appropriate action.

CPG Guidelines
The MCOs will review Clinical Practice Guidelines (CPGs) for the following diagnosis: Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Substance Use Disorder, Schizophrenia, Generalized Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, and Suicide Risk.

On-site vs. desk audits
Treatment record reviews will be conducted via desk reviews as well as onsite. Any planned onsite reviews will be completed in accordance with safety protocols within LDH guidelines.

On-site review criteria include the following: voluntary agreement between provider and MCO; provider previously non-compliant and/or non-responsive to PQM request letter; and provider failed their most recent PQM review.

Member Surveys
MCO will survey 5% of randomly selected members who have received services from the identified provider. 2 call attempts are made per identified member before moving on to the next identified member and/or a letter is sent requesting a response within 2 weeks. The MCO may send additional letters and/or attempt phone calls to engage the member.

Results Review
Each MCO will conduct meetings as needed to review results and address any identified issues and/or concerns that may potentially require additional referrals.

Identification of issues
Any reviewed provider that shows evidence of Fraud, Waste, Abuse, and/or potential quality of care concerns is referred to the appropriate internal investigations department within each MCO. Quality of care concerns will also be reported to LDH per MCO contract requirements.

Corrective Action Plans (CAPs)
With the exception of independently practicing LMHPs (non-roster staff), providers are placed on corrective action plans when overall scores are less than 80%. A referral to the MCO's appropriate department for potential QOCC and/or FWA would be required, if identified. For non-LMHPs, if referral made to SIU, once SIU case is closed, CAP must be completed. MCOs will still report providers who fail to score 80% in the appropriate tables of the LA358 report and supply a narrative accordingly in the Resolution description cell. For example, John Doe, LCSW, scored 78% and upon review of items missed there is no indication of FWA or QOCC. MCO educated John Doe on ways to improve those items missed, encouraged him to attend offered MCO trainings, and offered resources to aid him, if needed. No further action needed. Another example, Jane Doe, LPC, scored 52% and upon review, there were concerns identified within her documentation which resulted in a referral to either SIU/QOCC. No further action needed for SIU. QOCC outcomes will be reported on the appropriate tab of LA358.

Subsequent reviews will be conducted by the MCOs though their corrective action plan process. The CAP re-review will be completed by ACLA within a 6-to-9-month time frame. Exception to be made if providers are unable to be re-reviewed due to no identified claims during look back period and the MCO will refer the provider to be placed on priority list via the LA 358. MCO will report on a quarterly basis the progression of growth and/or lack thereof towards implementation of interventions made by provider placed on CAP until the time that re-review occurs by the original MCO or the time that the provider is placed on the priority list at which point the original MCO will note on LA358 that the

provider has been reassigned to a different MCO for follow-up monitoring and is now closed.

Record Storage
All provider documentation obtained by the MCOs will first be scanned into a secure network drive only accessible to a selection of the MCO employees who require access to the drive for completion of PQMP reviews and QIC oversight.

For desktop reviews, the MCO shall maintain documentation used to determine the providers' compliance for a minimum of three years from the date of review.

Provider Education
The MCOs have drafted a training schedule to be offered on specified dates and times outlined through the end of the year 2023. Each MCO will conduct training for providers monthly. Future trainings will be developed and offered based on providers' need as well as when LDH Behavioral Health manual updates necessitate.

Trainings will also be offered upon provider request. Training attendance on the provider quality monitoring tool will be mandatory for any provider who fails to meet the overall 80% required to be considered passing for a review. Providers who fail a review will be required to work with the issuing MCO to coordinate a training to satisfy this requirement.

Attachments


All MCO PQM Letters_Final_0907202