PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **March 26, 2025**

Subject: **LDH Approved Policy – Provider Quality Management**

Summary: Policy for Provider Quality Management

AmeriHealth Caritas Louisiana would like to make you aware of a new policy that has been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guideline will be located at the following link on our website: https://www.amerihealthcaritasla.com/pdf/provider/provider-quality-monitoring-strategy.pdf.

Reminder: If your practice is not registered with our website portal-NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert? You can find a complete list of provider alerts on our website's Provider Newsletters and Updates page.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com.

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Provider Quality Monitoring (PQM) Policy

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.

***Model Contract*: 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 enrollee participation, the quality of the assessment and treatment plan, whether enrollees 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.

Reference: Louisiana Medicaid Managed Care Organization (MCO) Manual, updated 2/2/2024, Part 13: Quality, p. 239: Quality Monitoring Reviews for Behavioral Health Providers.

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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 Nurse

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.
    - 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

- Healthy Blue: 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.
- Request for Medical Records and Notification of Pass/Fail as well as Deficiencies Letters
- 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 (IRR)

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.

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All MCO IRR Process

1. Each MCO will provide one redacted record consisting of only the treatment plan and progress notes.

2. Standardized records will be kept on repository for future use at each MCO.

    a. All six (6) standardized records will be sent to and stored at each MCO via key representatives.
    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%-87%, 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 according to the individual MCO processes.

3. 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, 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 including ASAM Levels 3.1, 3.2-WM, 3.3, 3.5, 3.7 Adult, and 3.7-WM

*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 calendar year 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 meet the following criteria:

- Have not been reviewed by MCOs within a calendar year, and
- Have at least 5 unique members with at least 3 claims each, submitted 9 months from the date that the provider list is to be submitted to the MCO Master List holder.
- *Exception*: Crisis Response Services and Personal Care Services with identified claims on at least 1 member that have been submitted 9 months from the date that the provider list is to be submitted to the MCO Master List holder. (*Crisis Response Services includes Crisis Stabilization, Mobile Crisis Response, Community Brief Crisis Support, and Behavioral Health Crisis Care.)*

This due date is the 15th of the second month each quarter preceding the review quarter. Example, provider list submissions to the MCO Master List holder for Q2 2024 is due February 15, 2024.

Ineligible providers will meet one of the following criteria:

- Are those who have been reviewed within the same calendar year,
- Have passed their review with a score of 90% or greater within 24 months from the date of the last review.

Ineligible providers will be identified as a "-1" on the provider list that is to be submitted to the MCO Master List holder. Providers who are under active Special Investigations Unit (SIU) investigation will not be reviewed by the MCO they are being investigated by but will still be eligible for review by the remaining MCOs who do not have any active investigations open on the provider(s). These providers will be considered "no claims" providers rather than "-1" and would not be placed on the provider list that is to be submitted to the MCO Master List holder by the MCO with the active SIU investigation.

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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 which MCO would be assigned the provider requiring the priority review and attempt completion of the 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 report 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 will identify the following:

1. Which MCO is contracted with the provider,
2. Which MCO has identified claims with the provider, and
3. Which MCO is assigned to complete the provider's priority review.

Review of the provider must 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 must include on table 6 and/or within the narrative portion of the LA358 report the rationale of why the review is not completed. Additionally, if there is a provider on the priority list that your MCO is listed as being the originating MCO or the provider 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.

- Originating MCO example: 123 Grow is placed on the priority list as a referral from made by MCO 3. As a result, MCO 3 cannot be the assigned MCO for completing the priority review.
- SIU example: 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:

2024 Q1	Humana
2024 Q2	UHC
2024 Q3	LHCC
2024 Q4	ACLA
2025 Q1	AETNA

2025 Q2	Healthy Blue
2025 Q3	Humana
2025 Q4	LHCC
2026 Q1	UHC
2026 Q2	ACLA
2026 Q3	AETNA
2026 Q4	Healthy Blue

Sampling Approach

The sample shall be random and include providers who have not been already reviewed by MCOs within a calendar year and who have at least 5 unique members with at least 3 claims each, submitted 9 months from the date that the provider list is to be submitted to the MCO Master List holder. Exception: Crisis Response Services and Personal Care Services with identified claims on at least 1 member that have been submitted 9 months from the date that the provider list is to be submitted to the MCO Master List holder. (*Crisis Response Services includes Crisis Stabilization, Mobile Crisis Response, Community Brief Crisis Support, and Behavioral Health Crisis Care.)* 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 sample 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 (refer to frequency of reviews), the total number of providers shared across MCOs is 80. The list of 80 providers is deduplicated and used to determine the 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 9 months from the date that the provider list is to be submitted to the MCO Master List holder. 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 for quality monitoring review (if not already part of the generated sample).

Ineligible providers will meet one of the following criteria:

- Are those who have been reviewed within the same calendar year which includes those providers with claims at a different level of care than previously reviewed using the same G-NPI and TIN,
- Have passed their review with a score of 90% or greater within 24 months from the date of the last review.

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Records Audited

A reasonable number of records at each site shall be reviewed to determine compliance. A minimum of five (5) unique members with at least three (3) claims each per site will be reviewed. An exception may occur and less records reviewed for PCS and CRS providers as well as if a selected provider has seen fewer than five (5) MCO members for Priority reviews.

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 the MCO receives no response within

the time frame allotted, each MCO will follow their own internal procedures for possible escalation and/or referral for providers previously non-compliant and/or non-responsive to PQM request letter.

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**.** At least 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.

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Results Review

Each MCO will conduct meetings as needed to review results**,** provide education**,** 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. Each MCO will follow their own internal policies and procedures to address any identified issues/concerns.

Corrective Action Plans (CAPs)

Except for independently practicing LMHPs and a group 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 Quality of Care Concerns (QOCC) and/or Fraud, Waste, and Abuse (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. Each MCO has their own unique process to handle corrective action plans. The CAP re-review will be completed by the MCO 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. 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.