Aetna Better Health of 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 Aetna Better Health of Louisiana (Aetna).

AUDIT OVERVIEW

The purpose of the audit was to assess Aetna'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 Aetna'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 Aetna 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 Aetna in December 7–8, 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	114	8	1	0	0	93%
Provider Network	163	145	16	1	1	0	89%
Utilization Management	92	39	52	0	0	1	43%
Eligibility, Enrollment and Disenrollment	13	12	1	0	0	0	92%
Marketing/Member Education	77	74	2	0	1	0	96%
Member Grievances and Appeals	62	52	10	0	0	0	84%
Quality Management	86	81	3	0	0	2	96%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	105	0	0	0	0	100%
TOTAL	**722**	**623**	**92**	**2**	**2**	**3**	**87%**

As displayed in the above, 722 elements were reviewed; 92 were determined to be "substantially met," 2 "minimally met," 2 "not met," and 3 were not applicable. The remaining 623 were "fully met." The overall compliance score was 87%.

It is IPRO's and the LDH's expectation that Aetna submit a corrective action plan for each of the 96 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that Aetna 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. Eighteen (18) of the 96 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 Aetna**.**

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 Aetna

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
Core Benefits and Services					
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.	A-LA 7000.43 Coordination of Member Care, pages 3-5.	Substantial	The policy provided (7000.43) concerns coordinating care. There is no language in that policy that addresses this requirement. Following the onsite interview, the MCO updated Policy 7000.50 (Supporting Members in Crisis) and added the contract language for this requirement. The update occurred after the review period.	
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.	A-LA 7000.43 Coordination of Member Care, page 6.	Substantial	Policy 7100.05 addresses when the plan and the treating physician cannot agree on a member's care in regard to post-stabilization services, but not initial emergency services. <u>Recommendation:</u> The MCO should include language in the Prior Authorization policy that addresses this requirement as it pertains to emergency services.	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in 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	A-LA 7500.05 Integrated Care Management, pages 13-14.	Substantial	The requirement is addressed in 7500.05, except for the submission of member care plans within 30 days of assessment. During the onsite interview, the MCO presented the Aetna website link for providers. On that tab of the website, there is a link for Behavioral Health, and on that tab there is a link for Prior Authorization. Here, the website states "Assessment, LOCUS score and Treatment Plan is	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	completion of the initial assessment or annual reassessment.			required initially and then every 365 days." <u>Recommendation:</u> Include "within 30 days following the assessment," or similar language, to the website so providers are aware of their time frames for submission.	
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 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 staffings.	AMA 7000.43 Coordination of Member Care LA, page 3.	Substantial	There is no evidence within the provided policy (7000.43) which supports this requirement. During the onsite interview, the MCO stated that they have liaison(s) for various agencies, including those that are part of the court system. However, there was no other, more substantial evidence of the MCO's coordination with the court system. <u>Recommendation:</u> The MCO should operationalize its dealings with the court system into a P&P for such interactions.	
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	AMA 7000.43 Coordination of Member Care LA, pages 2-3, 7. AMA 7500.05 Integrated Care Management, pages 7 and 12.	Minimal	The documentation provided satisfies the second component of this requirement. However, none of the other components are addressed within the policies.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	from psychosocial guidance in adapting to a newly diagnosed chronic medical 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.				
6.35.9.1.5	Develop capacity for enhanced rates for incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- of full-time in a psychiatric specialty setting to monitor the physical health of patients.	AMA 8000.50 Pay for Quality, pages 2-3.	Substantial	There is no evidence in the provided policy (8000.50) to satisfy this requirement. Following the onsite interview, the MCO updated policy 7000.66 "Patient-Centered Medical Home" to include language similar to the contract wording, which provides for incentives for clinics to hire a PCP. However, the update occurred after the review period	
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.	LA Provider Manual Fall 2016: Medical Records, page 27.	Substantial	In the Provider Manual, page 28, there is a list of requirements for provider medical records, which includes an item that reads "Documentation related to requests for release of information and subsequent releases." However, there is no documentation of the distribution of forms or training on how to use them. Following the onsite interview, the MCO provided policy 3000.51 "Use and Disclosure of PHI," which notes that forms are available from the MCO's compliance department. However, there is still no evidence of training for providers regarding the use of PHI forms.	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	AMA 8000.50 Pay for Quality, pages 2-3	Substantial	The policy provided as evidence (8000.50) describes a pay-for-performance program for providers who perform well on specific measures, not for integrated care. However, following the onsite interview, the MCO updated policy 7000.66 "Patient-Centered	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Medical Home" to include language that provides for incentives for behavioral health clinics to hire a PCP. <u>Recommendation:</u> The MCO should expand the incentives noted in Policy 7000.66 to apply to PCP offices that are providing basic behavioral health screens and care for members.	
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 Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Substantial	Page 7 of the policy provided states that it "works with members to address issues related to their asthma, diabetes, heart failure, COPD, CAD, depression, and any other condition as required by the state." However, the policy does not address high utilizers of the ED or inpatient services.	
Provider Network					
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.	A-LA 6100.06 Network Adequacy Measurement	Substantial	Not all access standards were met as noted below.	
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	A-LA 6100.06 Network Adequacy Measurement	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 2. The MCO's standard used to analyze compliance with LDH distance/travel standards for Urban PCPs does not match.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	not exceed 10 miles			Urban = 1 provider within 20 miles; the LDH standard is 10 miles. GEO Access Results: **Family/General Practice** Urban = 99.7% with access; 0.3% without access Rural = 100% with access **Pediatrics** Urban = 98.7% with access; 1.3% without access Rural = 97.4% with access; 2.6% without access **Internal Medicine** Urban = 98.3% with access; 1.7% without access Rural = 97.7% with access; 2.3% without access Recommendation: The MCO should update the GEO Access software to ensure analysis is based on the exact standards outlined in the contract.	
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.	Bayou Health Reporting, Network Provider Development Plan,	Substantial	The requirement is addressed in Bayou Health Reporting, Network Provider Development Plan, page 3. The MCO's standard used to analyze compliance with LDH distance/travel standards for Urban Hospitals does not match. Urban = 1 hospital within 20 miles; the LDH standard is 10 miles. GEO Access Results: Urban = 98.8% with access; 1.2% without access Rural = 99.8% with access; 0.2% without access Recommendation: The MCO should update the GEO Access software to ensure analysis is based on the exact standards outlined in the contract.	
7.3.3 7.3.3.1 7.3.3.2	Specialists • Travel distance to each specialty type shall not	A-LA 6100.06 Network Adequacy Measurement	Minimal	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 3.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.3.3.3 7.3.3.4	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.			The MCO's standard used to analyze compliance with LDH distance/travel standards for specialists is more stringent than LDH standards. For GEO Access analysis, the MCO's standard for urban provider types is 20 miles and the standard for rural provider is 30 miles. <u>Geo-Access Report Results</u> **Allergy/Immunology** Urban = 94.0% with access; 6.0% without access Rural = 48.6% with access; 51.4% without access **Anesthesiology** Urban = 96.5% with access; 3.5% without access Rural = 90.5% with access; 9.5% without access **Audiology** Urban = 88.2% with access; 11.8% without access Rural = 54.1% with access; 45.9% without access **Cardiology** Urban = 97.6% with access; 2.4% without access Rural = 91.8% with access; 8.2% without access **Chiropractic** Urban = 84.3% with access;15.7% without access Rural = 63.8% with access; 36.2% without access **Dermatology** Urban = 86.9% with access; 13.1% without access Rural = 52.9% with access; 47.1% without access **Emergency Medicine** Urban = 98.8% with access; 1.2% without access Rural = 97.8% with access; 2.2% without access **Endocrinology and Metabolism** Urban = 77.3% with access; 22.7% without access Rural = 37.7% with access; 62.3% without access **Gastroenterology**	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urban = 90.4% with access; 9.6% without access Rural = 55.4% with access; 44.6% without access **Hematology/Oncology** Urban = 95.3% with access; 4.7% without access Rural = 62.8% with access; 37.2% without access **Hospice** Urban = 89.8% with access; 10.2% without access Rural = 86.7% with access; 13.3% without access **Infectious Disease** Urban = 93.5% with access; 6.5% without access Rural = 56.6% with access; 43.4% without access **Neonatology** Urban = 81.8% with access; 18.2% without access Rural = 42.4% with access; 57.6% without access **Nephrology** Urban = 94.4% with access; 5.6% without access Rural = 64.2% with access; 35.8% without access **Neurology** Urban = 96.2% with access; 3.8% without access Rural = 63.1% with access; 36.9% without access **Nuclear Medicine** Urban = 80.4% with access; 19.6% without access Rural = 43.5% with access; 56.5% without access **OB/GYN** Urban = 98.7% with access; 1.3% without access Rural = 90.5% with access; 9.5% without access **Occupational Therapy** Urban = 81.5% with access; 18.5% without access Rural = 58.7% with access; 41.3% without access **Ophthalmology** Urban = 96.8% with access; 3.2% without access	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Rural = 76.8% with access; 23.2% without access **Optician/Optometry** Urban = 98.5% with access; 1.5% without access Rural = 99.5% with access; 0.5% without access **Orthopedics** Urban = 95.1% with access; 4.9% without access Rural = 85.4% with access; 14.6% without access **Otolaryngology** Urban = 91.9% with access; 8.1% without access Rural = 79.3% with access; 20.7% without access **Pathology** Urban = 89.7% with access; 10.3% without access Rural = 51.3% with access; 48.7% without access **Pediatric Allergy** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Pediatric Cardiology** Urban = 90.0% with access; 10.0% without access Rural = 49.2% with access; 50.8% without access **Personal Care Services** Urban = 80.6% with access; 19.4% without access Rural = 57.8% with access; 42.2% without access **Podiatry** Urban = 97.1% with access; 2.9% without access Rural = 79.5% with access; 20.5% without access **Pulmonary Medicine** Urban = 94.1% with access; 5.9% without access Rural = 59.9% with access; 40.1% without access **Radiology - Diagnostic** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Radiology - Therapeutic Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Rheumatology** Urban = 88.4% with access; 11.6% without access Rural = 37.5% with access; 62.5% without access **Speech Therapy** Urban = 79.5% with access; 20.5% without access Rural = 48.9% with access; 51.1% without access **Surgery Cardiovascular** Urban = 97.6% with access; 2.4% without access Rural = 91.8% with access; 8.2% without access **Surgery – Colon & Rectal** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Surgery – General** Urban = 97.4% with access; 2.6% without access Rural = 94.7% with access; 5.3% without access **Surgery – Neurological** Urban = 80.3% with access; 19.7% without access Rural = 23.2% with access; 76.8% without access **Surgery – Pediatric** Urban = 71.1% with access; 28.9% without access Rural = 10.7% with access; 89.3% without access **Surgery – Plastic** Urban = 80.4% with access; 28.9% without access Rural = 29.5% with access; 70.5% without access **Surgery – Thoracic** Urban = 93.8% with access; 6.2% without access Rural = 61.6% with access; 38.4% without access	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Urology Urban = 94.8% with access; 5.2% without access Rural = 76.7% with access; 23.3% without 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.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
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.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
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.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access Results: **Psychiatric Residential Treatment Facilities** Urban: 46.4% with access; 53.6% without access Standard used is 1 provider within 15 miles. Rural: 9.3% with access; 90.7% without access. Standard used is 1 provider within 30 miles.	
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	A-LA 6100.45 Network Development, Composition,	Substantial	The requirement is partially addressed in Bayou Health Network Provider Development Management Plan, page 8.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. 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.	Adequacy Access Standards & System Monitoring		Language was not found that addresses the requirement of one hospital that provides ER services, inpatient, and outpatient care in each parish; Level III OB services; Pediatric Services, and Children's Hospital that meets CMS definition. During the onsite, the MCO stated that the requirement is addressed in GEO Access reports. Plan agreed with suggestion to list these specific services in the network development plan.	
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.		Substantial	The MCO did not provide evidence of coordination with OBH. Such evidence may include shared policies, memos or MOUs. MCO: We coordinate whatever our public health initiatives are. We have never had to contact OPH to coordinate public health activities.	
	• 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	Bayou Health Specialized Behavioral Health Network Development and Management	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 6. The language in the referenced document does not specifically state the elements required. During the onsite, the MCO stated that they conduct assessments on a monthly basis using GEO Access reports.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and telemedicine referrals for specialized behavioral health services; • Specialized behavioral health service needs of members; and • Growth trends in eligibility and enrollment, including: ○ Current and anticipated numbers of Title XIX and Title XXI eligibles; and ○ 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.			Providers who are being offered single case agreements are also being offered contracts to join the network. All of these elements are being used to support network development. <u>Recommendation</u>: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	
	• Accessibility of services, including: ○ 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,	Network Provider Development Plan	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 6-7. The language in the referenced document does not specifically state the elements required. <u>Recommendation</u>: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	reoccurring basis as close to real time as possible; ○ The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; ○ Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and ○ Any service access standards detailed in a SPA or waiver.	A-LA 6100.45 Network Development Compositions, Adequacy, Access Standards & System Monitoring			
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	Network Provider Development Plan	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 8. The language in the referenced document does not specifically state the elements required. During the onsite, the MCO stated that they will update development plan to include all elements. <u>Recommendation</u>: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	contract; • 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	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 8. The language in the referenced document does not specifically state the elements required. During the onsite, the MCO stated that they will update development plan to include all elements. <u>Recommendation</u>: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
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	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 8-10. The referenced document does not include provider requirement for annual training, the sharing of provider satisfaction results, etc. During the onsite, the MCO stated that they will update Provider Manual and send the auditor the updated version. The MCO is in the process of concluding the 1st provider satisfaction survey. Results will be shared with providers. The MCO submitted a revised Provider Manual that includes language regarding annual training.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development	Bayou Health Reporting, Network Provider Development Plan	Substantial	The Bayou Health Reporting Network Provider Development Plan includes language regarding MCO steps for monitoring and evaluating network development and management plan and policy	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and 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.			and procedures, however, it does not clearly state whether or not the results of monitoring and evaluation activities would be included in subsequent network development reports. <u>Recommendation</u>: Update Bayou Health Reporting Network Provider Development Plan to include a specific section for the evaluation of the previous year's network development plan.	
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 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).	LA – 8100.32 LA – 8100.32A	Not Met	Language is not found in referenced document. Post Onsite: MCO submitted a revised LA – 8100.32A which includes the language in this requirement, making the MCO fully compliant but the change was made after the review period and after the onsite visit.	
Utilization Management					
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM)	A-LA 7100.05 Prior Authorization Reporting – p 21 and Decision/Notificatio	Substantial	All deficiencies in UM policies and procedures were discussed onsite with the MCO, which provided additional information post-onsite where noted below. The MCO explained onsite that some Louisiana contract specific language	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.	n Requirements pp 14 – 15 Decision/Notification Time Standards P 12 A-LA 7200.05 Concurrent Review: Inpatient QM/UM Committee Agenda Exhibit 1 QM/UM Minutes 7.20.2016 – Exhibit 2		had been removed from some policies and procedures by the Corporate office. The MCO stated that any deficient P/Ps will be amended to include Louisiana specific contract language. <u>Recommendation</u>: The MCO should amend relevant P/Ps to include Louisiana specific contract language as required for compliance with the Louisiana State contract.	
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;	Pre-onsite: 2016 UM Program Description Discharge Planning p 22 Post-onsite: A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4	Substantial	Prior to the onsite, contract language was not found in 2016 UM Program Description, Discharge Planning p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. <u>Recommendation</u>: The MCO has updated the referenced policy to meet 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;	2016 UM Program Description p 22 A-LA 7000.43 Coordination of Member Care p 4	Substantial	Prior to the onsite, the Contract language was not found in 2016 UM Program Description p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. <u>Recommendation</u>: The MCO has updated the referenced policy to meet this requirement.	
8.1.3.11	Collaborating with the	2016 UM Program	Substantial	The contract language was not found in the 2016	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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	Description p 22 Post-onsite: A-LA 7000.43 Coordination of Member Care p. 4		UM Program Description p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. <u>Recommendation</u>: The MCO has updated the referenced policy to meet this 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.	2016 UM Program Description p 22 A-LA 7000.43 Coordination of Member Care p 4	Substantial	The contract language was not found in the 2016 UM Program Description p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. <u>Recommendation</u>: The MCO has updated the referenced policy to meet this requirement.	
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.	Pre-onsite: 2016 UM Program Description Medical Necessity Criteria PP 16-17 A-LA 8000.50 Pay for Quality Focus/Disposition pp 2-3 Post-onsite: A-LA 7000.30 Approval Process of Medical Necessity Criteria ABH LA Medicaid Compliance Addendum Provider	Substantial	Prior to the onsite, the contract language was not found in either submitted document, and provider contracts were not submitted for review. The compliance report, (069) UM Medical Record Review Summary Rpt_ 10302015 - 8.13.0, provides evidence of implementation of this requirement. Post-onsite, the MCO updated the Policy A-LA 7000.30 Approval Process of Medical Necessity Criteria to include the contract language, and submitted the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016, pg. 21. <u>Recommendation</u>: The MCO updated the Policy A-LA 7000.30 Approval Process of Medical Necessity Criteria to include the contract language, and submitted the template provider contract ABH LA Medicaid	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		- Exhibit A - V.5.12.2016, pg. 21		Compliance Addendum Provider, pg. 21, to meet compliance with the addition of the compliance report, (069) UM Medical Record Review Summary Rpt_ 10302015 - 8.13.0.	
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.	A-LA 7100.05 Prior Authorization pp 2 - 3 p 13	Substantial	Prior to onsite the language, "Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines" was not found in the submitted document. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization p. 17 to include the required language. <u>Recommendation</u>: The MCO updated the policy A-LA 7100.05 Prior Authorization p. 17 to include the required language which meets the requirement.	
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.	A-LA 7100.05 Prior Authorization p 5, pp 11 - 12	Substantial	Prior to the onsite, the full contract language was not found in the submitted policy. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization pgs. 15-16 to include the required language. <u>Recommendation</u>: The MCO updated the policy A-LA 7100.05 Prior Authorization pgs. 15-16 to include the required language which meets the requirement.	
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	A-LA 7100.05 Prior Authorization, pg. 12 A-LA 7200.05 Concurrent Review: Inpatient pp 8 - 9	Substantial	Prior to the onsite the contract language was not found in either submitted policy. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization pg. 17 to include the required language.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.			Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization pg. 17 to include the required language which meets 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.	2016 UM Program Description P 12 – 13 A-LA 7200.05 Concurrent Review: Inpatient P 10 A-LA 7100.05 Prior Authorization P 12 Post-onsite: Org.Chart A-LA 7100.05 Prior Authorization pg. 16	Substantial	Prior to the onsite, all required language was not found in the submitted documents; a staffing plan was not submitted for review. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language, and submitted an organization UM staffing chart. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language, and also submitted an UM staffing chart which meets the requirement.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite the MCO did not submit a staffing plan. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization and submitted an organization UM staffing chart. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization and also submitted an UM staffing chart to meet the requirement.	
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	A-LA 7000.08 Clinical Personnel License Requirements PP 1-2 Post-onsite: A-LA 7100.05 Prior Authorization pg. 16	Substantial	Prior to the onsite, the P/P A-LA 7000.08 was not submitted for review. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.			Authorization pg. 16 to include the required language.	
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.	2016 UM Program Description P 13 A-LA 7000.08 Clinical Personnel License Requirements P 13 Post-onsite: A-LA 7100.05 Prior Authorization pg. 16	Substantial	Prior to the onsite, the requirement was not met in the 2016 Program Description, and as noted above, the P/P A-LA 7000.08 Clinical Personnel License Requirements pg. 13 was not submitted for review. Post-onsite, the policy A-LA 7100.05 Prior Authorization pg. 16 was revised to include required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 16 to include required language, meeting the requirement.	
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	A-LA 7500.05 Integrated Care Management P 13 A-LA 7000.40 Member Transition P 5 Post-onsite: A-LA 7100.05 Prior Authorization pgs. 16-17	Substantial	Prior to the onsite, the required language was not found in P/Ps 7500.05 or A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 16-17, to include required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 16-17 to include required language, meeting the requirement.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	(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.				
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;	A-LA 7100.05 Prior Authorization p 10	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization pg. 10. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 11, to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 11 to include required language, meeting the requirement.	
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	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite, the element language: "and effective dates for authorization to participating providers and applicable non-participating providers" was not found in A-LA 7100.05 Prior Authorization pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language, meeting the requirement.	
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	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language. Recommendation:	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	for notification of providers and members of decisions.			The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language, meeting the requirement.	
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.	A-LA 7100.05 Prior Authorization P 5 2016 UM Program Description P 17 Post-onsite: A-LA 7200.05 Concurrent Review Inpatient	Substantial	The contract language not found in either policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review Inpatient to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7200.05 Concurrent Review Inpatient pg. 13 to include the required language, meeting the requirement.	
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.	A-LA 7100.05 Prior Authorization PP 9-11 PP 5-7 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	The contract language was not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2) pg. 10 to include the required language, meeting the requirement.	
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].	A-LA 7200.05 Concurrent Review: Inpatient pg. 10 Post onsite: A-LA 7200.05 Concurrent Review: Inpatient pg. 6	Substantial	The contract language not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient, pg. 6 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient pg. 6 to include the required language, meeting the requirement.	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These	A-LA 7200.05 Concurrent Review: Inpatient pgs. 9-10	Substantial	The contract language not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA	

Contract Reference	Contract Requirement Language	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.	Post onsite: A-LA 7200.05 Concurrent Review: Inpatient pgs. 4-5		7200.05 Concurrent Review: Inpatient, pgs. 4-5 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient pgs. 4-5 to include the required language, meeting the requirement.	
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	A-LA 7200.05 Concurrent Review: Inpatient Definitions pp 2-5 Behavioral Health Admissions and Treatment PP 8-9 Definitions PP 11-12 Decisions/Notification Time Standards PP 11-12 Definitions PP 2-6 Emergency P 5 Urgent P 6	Substantial	The element language was not found in the policy A-LA 7200.05 Concurrent Review: Inpatient Definitions pgs. 2-12, prior to the onsite. Evidence of timely submissions, and a template for notification communication to member/provider was not submitted for review. Post-onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient, pgs. 9-10 to include required language. <u>File Review Results</u>: None (0) of the ten (10) UM denial files reviewed onsite involved an inpatient psychiatric hospitalization concurrent UR; results are NA for this element. <u>Recommendation</u>: The MCO updated the policy A-LA 7200.05 Concurrent Review: Inpatient, pgs. 9-10 to include required language; evidence of timely submissions, and a template for notification communication to member/provider.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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 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				

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	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, 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				

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
8.5.1.2	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.	A-LA 7200.05 Concurrent Review: Inpatient, pg. 3 and pg. 12 A-LA 7100.05 Prior Authorization, pg.4 and pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 21	Substantial	Prior to the onsite, the element percentages were not found in the submitted policies. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, p. 6, pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 19	Substantial	The requirement language was not found in one statement but in different areas of the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 19 to include required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for notification of the circumstances under which expedited resolution is available and how to request it; six (6) of the ten (10) files were not compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 19 to include required	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				language, and to meet compliance. The MCO should include the circumstances under which expedited resolution is available and how to request it in notification letters.	
8.5.2.2	The MCO may extend the seventy-two (72) 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.	A-LA 7100.05 Prior Authorization, p. 6, pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 22	Substantial	Prior to the onsite, the submitted policy excluded "justifies to DHH" language. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 22 to include required language. <u>File Review Results:</u> None (0) of the ten (10) UM denial/adverse action files reviewed onsite involved an extension; results are NA for this element. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 22 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, pgs. 14-15, p. 19 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 25	Substantial	The following language was not found in the submitted policy prior to the onsite, "but in no instance later than one hundred, eighty (180) days from the date of service." Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language. <u>File Review Results:</u> All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language, and to meet compliance.	
8.5.3.2	The MCO shall not subsequently retract its authorization after	A-LA 7150.05 Medical Claims	Substantial	Prior to the onsite, the required language was not found in the submitted policy.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.	Review, pg 2 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 25		Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, pgs. 13-15. Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 18	Substantial	Prior to the onsite, the element language was not clearly stated as presented in the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 18 to include required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 18 to include required language, and to meet compliance.	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO 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	A-LA 7100.05 Prior Authorization15 – 16 Post-onsite: A-LA 7100.05 Prior Authorization (2), pgs. 18-19	Substantial	Prior to the onsite, the contract language was not found in the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pgs. 18-19 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pgs. 18-19 to include required language, and to meet compliance.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	initial certification.				
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 determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	A-LA 7100.05 Prior Authorization Decision/Notification Requirements p 14 – 15 Notice of Action Requirements pp 19-20 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 21	Substantial	Prior to the onsite, the submitted policy stated that the non-urgent pre-service denial notification method is Electronic/Written vs. verbal/oral on pg. 14 of Policy. Post-onsite, the MCO updated A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language, and to meet compliance.	
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.	2016 UM Program Description Peer to Peer Consultation PP 22-23 A-LA 7100.05 Prior Authorization P 5 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.13	Substantial	Prior to the onsite, the 2016 UM Program Description, was not a dated policy in RP; it only addressed Peer to Peer vs., member's rights. The policy A-LA 7100.05 Prior Authorization, pg. 5 referenced "Peer to Peer," but not a member's rights. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 13 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 13 to include required	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				language, and to meet compliance.	
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)].	2016 UM Program Description P 23 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.13	Substantial	Prior to the onsite, the 2016 UM Program Description, was not a dated policy in RP; it only addressed Peer to Peer vs., member's rights. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 13 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 13 to include required language, and to meet compliance.	
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.	A-LA 3100.70 Member Appeals Definitions p.2 Scope p.8 Post-onsite: A-LA 3100.70 Member Appeals, pg. 9	Substantial	The submitted policy prior to the onsite had 30-day timeframe but not: "The Informal Reconsideration will in no way extend" element language. Post-onsite, the MCO updated the policy A-LA 3100.70 Member Appeals, pg. 9 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 3100.70 Member Appeals, pg. 9 to include required language, and to meet compliance.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient	A-LA 7100.05 Prior Authorization, pg.9 Post-onsite:	Substantial	The required contract language was not found in the submitted policy prior to the onsite.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	admissions for normal newborn deliveries.	A-LA 7100.05 Prior Authorization (2), pg. 9		Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	A-LA 7100.05 Prior Authorization, pg. 2 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.9	Substantial	Prior to the onsite, the policy did not state, "authorization or referrals"; states except EPSDT. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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.	A-LA 7000.40 Member Transition, pg. 4-6 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 9	Substantial	Prior to the onsite, the contract language was not found in the submitted policy A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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.	A-LA 7000.40 Member Transition, pg. 6 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 9	Substantial	Prior to the onsite, the contract language was not found in the submitted policy A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Authorization (2), pg. 9 to include required language, and to meet compliance.	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	A-LA 7100.10 Elective Referrals, pg. 8 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.	Substantial	Prior to the onsite, the policy A-LA 7100.10 Elective Referrals, pg. 8, states "for members under age 21." Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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.	A-LA 7000.42 Prenatal Services, pg. 7 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	Prior to the onsite, the contract language not found in the policy A-LA 7000.42 Prenatal Services, pg. 7. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
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.	Desktop: Obstetrical Admit for Deliveries, pg. 1 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	Prior to the onsite, the contract language was not found in the submitted document Desktop: Obstetrical Admit for Deliveries, pg. 1 which is not a signed policy. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
8.5.4.2	The MCO may require notification by the provider of	A-LA 7200.05 Concurrent Review:	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7200.05 Concurrent	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	inpatient emergency admissions within one (1) business day of admission.	Inpatient/Observation Setting, pg. 9 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10		Review: Inpatient/Observation Setting, pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization PP 9-11 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 15	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 15 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 15 to include required language, and to meet compliance.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	A-LA 7100.05 Prior Authorization Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Members pp 14-20 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14 ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016	Substantial	Prior to the onsite, the contract language was not found in the submitted policy or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language, and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template provider contract to meet compliance.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
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.	2016 UM Program Description Process for Making Determinations of Medical Necessity and Benefits Coverage pp 18-23 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14 ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016	Substantial	Prior to the onsite, the contract language was not found in the UM PD or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template provider contract to meet compliance.	
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.	A-LA 3000.18 Enforcement Mechanisms Focus/Disposition pp 2-4 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 3000.18 Enforcement Mechanisms Focus/Disposition, or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language, and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. <u>Recommendation</u>: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template provider contract to meet compliance.	
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental	A-LA 8000.34 Practitioner and Provider Performance Data	Substantial	The MCO stated onsite that they do not have BH profiling for 2015 as it was integrated in December 2015; signed BH attestations for January, April, July and October2016 were	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	Focus/Disposition, pp. 1-2 2016 UM Program Description Utilization Management Monitoring and Reporting pp 25-37		submitted for review. Prior to the onsite, the contract language is addressed in 2016 UM Program Description Utilization Management Monitoring and Reporting pg. 29, without a specific reference to BH providers. Post-onsite, the MCO revised the policy A-LA 8000.34, pg. 2 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pg. 2 to include the required language, and to meet compliance.	
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:	2016 UM Program Description P 28 Utilization/Performance Improvement Indicators pp 27-28 Behavioral Health Services P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data, pp. 2-3	Substantial	Evidence of timely submission of profiling report was submitted prior to the onsite, but the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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;	2016 UM Program Description P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data, pp. 2-3	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
8.12.3.2	Specialist referrals – The MCO	2016 UM Program	Substantial	Prior to the onsite, the contract language was not	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	Description P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data, pp. 2-3		found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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;	2016 UM Program Description, pg. 31	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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 UM Program Description P 27, 29 pp 25-37	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. <u>Recommendation</u>: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	2016 UM Program Description P 29 Utilization Management Monitoring and Reporting pp 25-37	Substantial	Element language for individual provider performance measures is addressed in the 2016 UM Program Description Utilization Management Monitoring and Reporting pgs. 25-37. It is unclear whether Appendix J has been retired and whether Appendix J measure results are required for compliance. <u>Recommendation</u>:	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				The MCO should clarify this requirement with LDH.	
Eligibility, Enrollment and Disenrollment					
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.	4500.01 Member Disenrollment Policy-Aetna Better Health Initiated Disenrollment, page 5.	Substantial	On page 5 of 4500.01, the requirement is addressed. However, in regard to the effective date, the policy only states "The notice includes… an explanation that Aetna Better Health is requesting that the member be disenrolled in the month following member notification." During the onsite interview, the MCO clarified that the effective date would be no earlier that the first of the month following the date of the notification to the member. The MCO has also updated the language within the policy to state the requirement verbatim following the onsite visit. The correction was made after the review period but no further action is necessary	
Marketing/Member Education					
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 ;	Member Handbook-Your member handbook (Language services)	Substantial	The requirement is partially addressed in Member Handbook, inside cover page, and pages 4, 12 and 16. The Member Handbook does not include a statement on how to obtain materials or translation services in Spanish. Onsite an approved draft of other member marketing materials was reviewed that has notification that a Spanish version is available. <u>Recommendation</u>: Update member handbook to include statements in both English and Spanish about the availability	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				of materials in alternative languages.	
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.	A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Department Provider Terminations Section A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Member Continuity of Care Section	Not Met	The A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations policy states on page 3 that the LDH will be notified within seven (7) business days, rather than seven (7) calendar days as noted in the requirement. The policy states on page 4 that members will be notified within fifteen (15) calendar days, rather than the seven (7) calendar days noted in the requirement. <u>Recommendation:</u> Revise policy to reflect correct timeframes noted in requirement.	
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	A-LA 4500.26 Translation Services Interpreter Services Section	Substantial	The requirement is partially addressed in A-LA 4500.26 Translation Services, page 2. The MCO policy states 5% or more, in conflict with the contract language which states 4% or more. During the onsite, the MCO stated that the plan does not have a primary language that is spoken by more than 4% of their membership. In addition, the MCO produces all written materials in Spanish.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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).			Recommendation: The MCO should revise the policy to reflect 4%.	
Member Grievances and Appeals					
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.	A-LA 3100.70 Member Appeals, pg. 7 Appeal Acknowledgment Letter Template Member Handbook, pg. 45	Substantial	The P/P A-LA 3100.70 Member Appeals, pg. 7 has the contract language but the contract language was not found in the Member Handbook, pg. 45, or in the letter template. Recommendation: The contract language should be added to the Member Handbook and to the confirmation letter template.	
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.	A-LA 3100.70 Member Appeals pg. 8 Member Handbook pg.46	Substantial	The P/P A-LA 3100.70 Member Appeals pg. 8 contains contract language. The contract language is not found in Member Handbook pg.46. File Review Results: Ten (10) of ten (10) appeal files reviewed included appeal acknowledgement letters that included in the following language: "You or your representative may see any information we reviewed about your appeal." Recommendation: The MCO should add the required language to the Member Handbook.	
13.4.2.4	Include, as parties to the appeal:	A-LA 3100.70	Substantial	The P/P A-LA 3100.70 Member Appeals pg. 8	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the member and his or her representative; or the legal representative of a deceased member's estate.	Member Appeals pg. 8 Member Handbook pg. 45		contains contract language. Contract language is not found in Member Handbook pg.45. File Review Results: Ten (10) of ten (10) appeal files reviewed demonstrated evidence of the requirement. Recommendation: The MCO should add the required language 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.	Learning Transcript	Substantial	Training Agendas and attachments and Sign-in sheets were not submitted for review. The submitted learning transcript does not indicate that training was for the LA Plan or was for grievance and appeal training. In response the MCO stated that it's an electronic sign in for all phone staff with mandatory compliance every two months. A report or some evidence of training taking place was requested onsite. Recommendation: The MCO should provide a training report or some evidence in support of this requirement.	
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.	A-LA 7100.05 Prior Authorization, pg. 19	Substantial	The requirement is addressed in A-LA 7100.05 Prior Authorization, pg. 19 but does not appear to be in any notice. Recommendation: A template Notice of Action letter or other documentation should be provided for review.	
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	A-LA 7100.05 Prior Authorization pg. 20	Substantial	The P/P A-LA 7100.05 Prior Authorization pg. 20 addresses this element. File Review Results: Of the ten (10) appeal files reviewed, none contained this language. This language is available in the member handbook. Recommendation:	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Notification of the member's right to continuation of benefits should be added to the appeal letter	
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.	A-LA 3100.70 Member Appeals, pg.14 Appeal Resolution Letter Denial Appeal Resolution Letter Approval	Substantial	The requirement is addressed in the P/P A-LA 3100.70 Member Appeals, pg.14, and in the Member Handbook, pg. 35. The Element Language "member may be held liable for the cost of those benefits if the hearing," was not found in the Appeal Resolution template letter. <u>File Review Results</u>: Of the ten (10) appeal files reviewed, six (6) denials were upheld. All six (6) upheld denial files demonstrated evidence of notification of right to a State Fair Hearing and how to do so. However, resolution letters did not include the right to request benefits while hearing is pending and that the member may be held liable for costs. Although this language is available in the member handbook, it should be added to the resolution letter.	
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.	A-LA 3100.70 Member Appeals, pg. 4	Substantial	The element language "representative of a deceased member's estate" was not found in P/P A-LA 3100.70 Member Appeals, pg. 4. <u>Recommendation</u>: The required language should be added to a P/P for Fair Hearings.	
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.	A-LA 3100.70 Member Appeals, pg. 9 Provider Handbook, pg. 78	Substantial	The required language is found in the P/PA-LA 3100.70 Member Appeals, pg. 9, but was not found in the Provider Handbook, pg. 78. <u>Recommendation</u>: The required language should be added to the Provider Handbook.	
13.7.4.2	The MCO shall inform the member of the limited time	Appeal Acknowledgment	Substantial	The MCO explained onsite that it is a verbal process to notify member as stated in P/P 3100.70	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Letter		member appeals pg. 14, where the limited time for a member to present evidence is implied, but not stated. Recommendation: The element language and the MCO process to notify members verbally should be added to the appeals policy.	
Quality Management					
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 membership.	LA Member Advisory Council Plan (5).pdf MAC_Committee_Q2_mtg_notes_5_17_16 MAC_Committee_Q3_mtg_notes_8_16_16 MAC_Q1_3_29_MtgNotes	Substantial	The requirement language is found in LA Member Advisory Council Plan (5), pg. 5. Evidence of at least one family member/caregiver of a child with special health care needs having representation on the committee, and members as 50% of membership was not provided or evident in the submitted meeting notes. Recommendation: The MCO should provide evidence of MAC composition in compliance with 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.	LA Member Advisory Council Plan (5).pdf	Substantial	The requirement language is found in LA Member Advisory Council Plan (5), pg.6. Recommendation: The MCO should provide training attendee lists and evidence of ongoing training.	
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	LA Member Advisory Council Plan (5).pdf 2016 139 Report Submissions.pdf MAC 139 ABH 2016 Q2.pdf Screenshot_MAC_	Substantial	The requirement is addressed in the Screenshot_MAC_Website.pdf which shows agendas posted for MAC meetings. Evidence of all agenda and Council minutes posted to the MCO website in English and Spanish, with any member-identifying information redacted was not submitted for review.	

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	redacted.	Website.pdf		Recommendation: All MAC council minutes for the RP should be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	

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;	A-LA 7500.05 Integrated Care Management: Outreach, page 8.	Full	Requirement is addressed on page 2 of the PSH Desktop, under Step 1.	
6.4.5.1.2	Assist members in completing the PSH program application;	A-LA 7500.05 Integrated Care Management: Care Plan Development, pages 11-12.	Full	Requirement is addressed on page 3 of the PSH Desktop, under Step 4.	
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 Desktop page 2	Full	The PSH Desktop document states that Case Management contacts the member within one business day to obtain this information, but the document does not discuss sharing this information with LDH. During the onsite visit, the MCO provided evidence of email	

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**
				communications between the MCO and LDH staff concerning PSH eligibility.	
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	PSH Desktop page 4	Full	The MCO indicates on page 4 of the PSH Desktop that CM follows up and documents information "in a timely manner". Recommendation: The MCO should organize this requirement into a formal policy.	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:				
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.	MCO Key Contact List, page 2.	Full	The MCO provided a contact list, which contains the key contact for the PSH program at the plan.	
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 tolls and protocols consistent with industry standards.	LA Provider Manual Fall 2016: Section 6; Behavioral health, pages 44-45	Full	The Provider Handbook contains a section discussing behavioral healthcare in a primary care setting and gives some guidance on providing behavioral healthcare within the primary care setting. Following the onsite interview, the MCO provided examples of the LOCUS training and LOCUS score sheets for providers' use, on which providers can score members' risk of harm, functional status, environmental stressors, etc. The MCO stated that it works with other MCOs to hold monthly LOCUS training for providers.	
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	LA Provider Manual Fall 2016: Section 9; Members with Special Healthcare Needs, pages 51-52.	Full	The Provider Handbook discusses the use of screenings in primary care settings for developmental, behavioral, and social delays. Following the onsite interview, the MCO provided examples of the	

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**
	increase screening for behavioral health needs in primary care.			LOCUS training and LOCUS score sheets for providers, which providers can score members' risk of harm, functional status, environmental stressors, etc. The MCO stated that it works with other MCOs to hold monthly LOCUS training for providers. Recommendation: The MCO should develop a work plan describing interventions and steps taken to increase the rate of these screenings.	
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, and 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.	LA Provider Manual Fall 2016: Section 4; Provider Responsibilities, pgs. 10-34.	Full	The Provider Handbook outlines the protocols for providers to engage in the processes outlined within this requirement.	
6.4.10	Develop a 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, psychiatric acute unit 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.	A-LA 7000.50 Supporting Members in Crisis, pages 4-5.	Full	Requirement is addressed by 7000.50, which outlines the crisis intervention and stabilization processes for members in crisis.	

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**
6.8	**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 services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Member Handbook for Integrated Health Services: Emergency Care, page 38.	Full	The Member Handbook explains that members can get emergency care at any time, regardless of whether the hospital is in the MCO's network, and that the member does not need prior approval for emergency care. The Handbook also explains that the MCO will cover emergency services, even if it is later determined that the condition of the member did not require emergency services. This can all be found on page 38 of the Member Handbook.	
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member Handbook for Integrated Health Services: Medicaid Covered Services; Non-Covered Services, pages 27-28.	Full	The Member Handbook states that members can receive emergency services out-of-service area without prior authorization.	
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.	Member Handbook for Integrated Health Services: If You Get a Bill or Statement, page 43.	Full	Page 43 of the Member Handbook states that members should not pay any bill received from a provider for covered services, including emergency care. The Handbook also states that if members are unsure of whether to go to the ER, their PCP or the Nurse Advice Line will tell them what to do.	
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.	Member Handbook for Integrated Health Services: Emergency Care, page 38.	Full	Page 38 of the Member Handbook explains that the plan pays for emergency medical treatment, and lists conditions that could constitute an emergency. Additionally, this section of the Handbook gives the plan's number for the behavioral health crises line, and instructs members to seek emergency care if they are experiencing either a medical or behavioral health emergency.	
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall	A-LA 7000.43 Coordination of Member Care, pages 3-5.	Substantial	The policy provided (7000.43) concerns coordinating care. There is no language in that policy that	

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**
	determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.			addresses this requirement. Following the onsite interview, the MCO updated Policy 7000.50 (Supporting Members in Crisis) and added the contract language for this requirement. The update occurred after the review period.	
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.	A-LA 7000.43 Coordination of Member Care, page 6.	Substantial	Policy 7100.05 addresses when the plan and the treating physician cannot agree on a member's care in regard to post-stabilization services, but not initial emergency services. Recommendation: The MCO should include language in the Prior Authorization policy that addresses this requirement as it pertains to emergency services.	
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 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.	A-LA 7000.43 Coordination of Member Care, page 7.	Full	Page 7 of 7000.43 addresses the MCO's policy for promoting cost-effectiveness of care. However, there is no language in the policy provided (7000.43) that addresses MCO efforts to address non-emergent use of the ED. Following the onsite interview, the MCO provided its work plan for reducing ED usage, which included interventions aimed at members and providers in order to reduce non-emergent use of the ED.	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	LA Provider Manual Fall 2016, page 24. Member Handbook for Integrated Health Services, pages 38 and 42.	Full	Page 24 of the Provider Manual states, under *Educating members on their own care*, that providers should advise members on treatment options. Page 38 of the Member Handbook informs members to only use the emergency room for true emergencies, and to contact their PCP for urgent care and not to go to the ER for urgent care. Page 42	

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**
				informs members on what to do for after hours care.	
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 purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.	A-LA 7000.43 Coordination of Member Care, pages 7-9.	Full	The policy provided (7000.43) does not address the components of this requirement. However, policy 7100.05 addresses the "test for appropriateness" component, and defines a "prudent layperson". Following the onsite interview, the MCO provided its work plan for reducing ED usage, which included interventions aimed at members and providers in order to reduce non-emergent use of the ED.	
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: If You Get a Bill or Statement, page 43.	Full	Page 43 of the Member Handbook states that members should not receive a bill from any provider for covered services, including emergency and post-stabilization services. The Handbook further instructs members not to pay any bills received and to call the plan if they do receive a bill for covered services.	
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:				
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 8 of 7100.05.	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	
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	A-LA 7100.05 Prior Authorization, page 8.	Full	The policy states that post-stabilization services are covered if the provider requested prior approval but the MCO did not respond within 1 hour of the request.	
6.8.2.1.2.2	Administered to maintain, improve, or resolve the member's stabilized condition if the MCO:	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	

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**
	• 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.				
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it 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;	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	
6.8.2.2.4	The member is discharged.	A-LA 7100.05 Prior Authorization, page 8.	Full	The requirement is addressed on page 7 of 7100.05.	
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, physical 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;				

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**
6.19.1.5	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 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 or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members 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.	AMA 7000.40 Member Transition LA, pages 1-2.	Full	The policy provided concerns the transition of members into or out of enrollment in the MCO, and does not address the identification of special health care needs of members. However, the PQ039 reports show the MCO tracks the number of members identified as SHCN, and how those members were identified, within 90 days.	
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	AMA 7000.40 Member Transition LA, pages 6-13.	Full	The policy provided concerns the transition of members into or out of enrollment in the plan, and does not address the identification of special health care needs of members. However, the PQ039 reports show the MCO tracks the number of members identified as SHCN. Additionally, policy 7500.05 outlines the process for engagement of members in integrate care	

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**
	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.			management, including SHCN members.	
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:	A-LA 7500.05 Integrated Care Management, pages 11-12.	Full	Policy 7500.05 describes the development of a person-centered care plan on page 11. The section titled *Eligibility* lists that populations that are prioritized for case management, and includes SHCN members.	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in 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.	A-LA 7500.05 Integrated Care Management, pages 13-14.	Substantial	The requirement is addressed in 7500.05, except for the submission of member care plans within 30 days of assessment. During the onsite interview, the MCO presented the Aetna website link for providers. On that tab of the website, there is a link for Behavioral Health, and on that tab there is a link for Prior Authorization. Here, the website states "Assessment, LOCUS score and Treatment Plan is required initially and then every 365 days." Recommendation: Include "within 30 days following the assessment", or similar language, to the website so providers are aware of their time frames for submission.	
6.19.4.2	In compliance with applicable quality assurance and utilization management standards.	A-LA 7500.05 Integrated Care Management	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	A-LA 7500.05 Integrated Care Management, pages 11-12.	Full	The policy provided states "The plan will also identify barriers/risks that may hinder the member's ability to reach goals or follow the care plan	

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**
	health services identified in the member's treatment plan.			and include activities designed to reduce those barriers." Page 4 of the policy includes members with special health care needs in the lists of members who are typical recipients of the ICM Program.	
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.	Member Handbook for Integrated Health Services, pages 36-37.	Full	Page 36 of the Member Handbook describes the Case Management program. Additionally, 7000.43 defines care management on the first page.	
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;	Member Handbook for Integrated Health Services, pages 36-37.	Full	Page 36 of the Member Handbook describes the Case Management program and that members can have a specialist acting as 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;	7000.43 Coordination of Member Care, page 5.	Full	The requirement is addressed on pages 5-6 of 7000.43.	
6.27.2.3	Care coordination and referral activities, in person or telephonically depending on the 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) requirement medical services, and coordination for members requiring behavioral health services.	A-LA 7500.05 Integrated Care Management, pages 5-6.	Full	The requirement is addressed in 7500.05 Page 5 of 7500.05 states that the plan identifies members who could benefit from care management via face-to-face and telephonic interaction with members, providers, or family members.	
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	A-LA 7500.05 Integrated Care Management, page 5 and 11.	Full	7500.05, page 5, states "Typical recipients [of Aetna's ICM Program] are those members: …with chronic	

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**
	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.			conditions for which care management and/or chronic condition management are required by contract…" Following the onsite interview, the MCO provided Policy 7500.03 "Member Restriction Program", which states that members are identified for "more than three (3) emergency room (ER) visits in ninety (90) days for pain".	
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 with 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 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.	AMA 7000.40 Member Transition LA, page 1. AMA 7000.43 Coordination of Member Care LA, page 3.	Full	The requirement is stated on page 1 of 7000.40, and nearly verbatim on pages 3-4 of 7000.43. Additionally, Policy 3000.17 outlines the plan's procedures for developing and implementing compliance program-related corrective action plans.	

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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**
6.29.1	The MCO shall be responsible for the coordination and continuity 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.	AMA 7000.40 Member Transition LA, page 2. AMA 7000.43 Coordination of Member Care LA, page 3.	Full	7000.43, page 4, states the first component of the requirement verbatim. On page 2 of that policy, there lists a series of external collaborators the plan works with to coordinate member care, which includes "State agencies", and the Office of Citizens with Developmental Disabilities would fall under this category.	
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.	AMA 7000.40 Member Transition LA, page 2.	Full	Each member is assigned or can choose a PCP, and the Member Handbook states that members can have a specialist acting as PCP.	
6.29.2.2	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	AMA 7000.40 Member Transition LA, page 2.	Full	7000.43, page 3, describes the referral process for coordinating care between PCPs and specialists.	
6.29.2.3	Coordinate care for out-of-network services, including specialty care services;	AMA 7000.40 Member Transition LA, page 2.	Full	7000.43, page 3, describes the referral process for coordinating care between PCPs and specialists, including out-of-network care.	
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	AMA 7000.40 Member Transition LA, page 2.	Full	7000.43, page 3, describes the referral process for coordinating care between PCPs and specialists.	
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;	AMA 7000.40 Member Transition LA, page 2.	Full	The requirement is addressed in 7500.05.	
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;	AMA 7000.40 Member Transition LA, page 2.	Full	The requirement is addressed on page 3 of 7000.40.	
6.29.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	AMA 7200.07, page 1.	Full	Policy 7200.07 outlines the plan's discharge program.	
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care ass appropriate, including	AMA 7200.07, page 1.	Full	Policy 7200.07 states that the plan's case management staff follow-up with members in order to ensure	

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	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:			coordination of care, including determining if a follow-up visit is scheduled, medication reconciliation, access to prescriptions, etc.	
6.29.2.8.1	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, RPTF's, and residential substance use disorder settings).	AMA 7000.43 Coordination of Member Care LA, pages 3-5.	Full	The requirement is addressed in 7200.07. Additionally, following the onsite interview, the plan provided its policy for pharmacy prior authorization.	
6.29.2.8.2	Care managers follow-up with members with a behavioral health-related diagnosis within 72 hours following discharge.	AMA 7000.43 Coordination of Member Care LA, page 6.	Full	7000.43 states that the plan initiates follow-up within 48 hours of a behavioral health emergency. During the onsite interview, the plan clarified that this follow-up is initiated within the 48 hours following discharge.	
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.	AMA 7000.43 Coordination of Member Care LA, page 6.	Full	The requirement is addressed throughout 7000.43.	
6.29.2.9	Document authorized referrals in its utilization management system; and	AMA 7100.05 Prior Authorization LA, page 1.	Full	The requirement is addressed on page 1 of 7100.05.	
6.29.2.10	Provide active assistance to members receiving treatment for chronic or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provider continuation of such services for up to ninety (90) calendar days or until the member is reasonable transferred without interruption of care, whichever is less.	AMA 7000.40 Member Transition LA, page 8	Full	The requirement is addressed on page 6 of 7000.40.	
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 court proceedings at the request of DHH when there is a need to inform the court of	AMA 7000.43 Coordination of Member Care LA, page 3.	Substantial	There is no evidence within the provided policy (7000.43) which supports this requirement. During the onsite interview, the MCO stated that they have liaison(s) for various agencies, including those	

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	available services and limitations, and participating in cross-agency staffings.			that are part of the court system. However, there was no other, more substantial evidence of the MCO's coordination with the court system. Recommendation: The MCO should operationalize its dealings with the court system into a P&P for such interactions.	
6.29.2.12	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	AMA 7000.43 Coordination of Member Care LA, pages 4-5.	Full	The requirement is addressed throughout 7200.07.	
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.	LA Provider Manual Fall 2016: Behavioral Health, page 45.	Full	The requirement is addressed on page 45 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 addiction are healthcare issues and 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	A-LA 7500.05 Integrated Care Management, pages 7-8; pages 11-12.	Full	Throughout 7500.05, there are references to care management integration of biological, psychological, and social needs of members. Additionally, there is evidence in the language of the Member Handbook that the MCO utilized the guiding principles outlined in this requirement as a basis for the integrated care management program.	

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	laws and other applicable standards of medical record confidentiality and the protection of patient privacy.				
6.35.3	In any instance when the member presents to the network provider, including calling the 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.	AMA 7000.43 Coordination of Member Care LA, page 6. A-LA 7500.05 Integrated Care Management, pages 11-12.	Full	The requirement is stated verbatim on page 6 of 7000.43.	
6.35.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	AMA 7100.05 Prior Authorization LA, page 8.	Full	Page 8 of 7100.05 describes the circumstances under which the MCO covers post-stabilization services.	
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.	AMA 7000.43 Coordination of Member Care LA, pages 4-5. AMA 7500.05 Integrated Care Management, pages 11-12.	Full	The requirement is stated verbatim on page 6 of 7000.43.	
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.	AMA 7000.43 Coordination of Member Care LA, pages 4-5. AMA 7100.10 Elective Referrals LA, pages 2-3.	Full	The requirement is stated verbatim on page 7 of 7000.43. Additionally, the plan provider Policy 7100.10, which describes the MCO's procedures for elective referrals.	
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.	AMA 7000.43 Coordination of Member Care LA, pages 4-5. AMA 7500.05 Integrated Care Management, pages 11-12.	Full	The requirement is stated verbatim on page 7 of 7000.43.	
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.	AMA 7000.43 Coordination of Member Care LA, page 7. AMA 7500.05 Integrated Care Management, page 16.	Full	The requirement is stated verbatim on page 7 of 7000.43.	
6.35.9 6.35.9.1.1 6.35.9.1.2 6.35.9.1.3	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of	AMA 7000.43 Coordination of Member Care LA, pages 2-3, 7.	Minimal	The documentation provided satisfies the second component of this requirement. However, none of the other components are	

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6.35.9.1.4	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 medical 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.	AMA 7500.05 Integrated Care Management, pages 7 and 12.		addressed within the policies.	
6.35.9.1.5	Develop capacity for enhanced rates for incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- of full-time in a psychiatric specialty setting to monitor the physical health of patients.	AMA 8000.50 Pay for Quality, pages 2-3.	Substantial	There is no evidence in the provided policy (8000.50) to satisfy this requirement. Following the onsite interview, the MCO updated policy 7000.66 "Patient-Centered Medical Home" to include language similar to the contract wording, which provides for incentives for clinics to hire a PCP. However, the update occurred after the review period	
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.	LA Provider Manual Fall 2016: Medical Records, page 27.	Substantial	In the Provider Manual, page 28, there is a list of requirements for provider medical records, which includes an item that reads "Documentation related to requests for release of information and subsequent releases". However, there is no documentation of the distribution of forms or training on how to use them. Following the onsite interview, the MCO provided policy 3000.51 "Use and Disclosure of PHI", which notes	

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				that forms are available from the MCO's compliance department. However, there is still no evidence of training for providers regarding the use of PHI forms.	
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;	Member Handbook for Integrated Health Services, page 38 LA Provider Manual Fall 2016, page 43.	Full	Both the Member Handbook and the Provider Manual discuss appropriate ER usage, including behavioral health emergencies.	
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;	AMA 7000.43 Coordination of Member Care LA, page 6.	Full	The requirement is addressed on page 6 of 7000.43.	
6.35.9.1.9	Ensuring continuity and coordination of care 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.	AMA 7000.43 Coordination of Member Care LA, page 6.	Full	The requirement is addressed on page 6 of 7000.43.	
6.35.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	AMA 7000.43 Coordination of Member Care LA, page 6.	Full	The requirement is addressed in 7000.43.	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	AMA 8000.50 Pay for Quality, pages 2-3	Substantial	The policy provided as evidence (8000.50) describes a pay-for-performance program for providers who perform well on specific measures, not for integrated care. However, following the onsite interview, the MCO updated policy 7000.66 "Patient-Centered Medical Home" to include language that provides for incentives for behavioral health clinics to hire a PCP. Recommendation: The MCO should expand the incentives noted in Policy 7000.66 to apply to PCP offices that are providing basic behavioral health	

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				screens and care for members.	
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;	LA Provider Manual Fall 2016, page 45.	Full	The requirement stated verbatim on page 7 of 7000.43.	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	AMA 7000.45 Interdisciplinary Case Rounds, pages 2-3.	Full	There is a statement in 7500.05 that states that interdisciplinary case rounds are conducted at least twice a month.	
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.	AMA 7500.05 Integrated Care Management LA, page 2.	Full	The MCO provided meeting minutes from quarterly meetings.	
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 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.	AMA 7500.05 Integrated Care Management LA, page 1.	Full	Policy 7500.05 has a general statement reading "The objectives of the policy are to describe how Aetna Better Health will: Maintain an Integrated Care Management Program designed to meet the needs of the member population served." Further in the policy, a description of the development of member care plans includes statements regarding including the member in the development of the care plan and the integration of members' strengths and needs into the care plan.	
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;	AMA 7500.05 Integrated Care Management LA, page 5.	Full	The requirement is addressed throughout 7500.05.	
6.38.2.2	Assessment of a member's risk factors;	AMA 7500.05 Integrated Care Management LA, page 5.	Full	Page 5 of 7500.05 states that the MCO gathers information from a variety of sources to assess members' risk factors.	
6.38.2.3	Education regarding patient-centered medical home and referral to a medical home when appropriate;	AMA 7500.05 Integrated Care Management LA, page 6.	Full	Page 6 of 7500.05 has a general statement regarding the needs of members, which includes the	

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				phrase "or needs information:, and that the program can be tailored to the member. Within the policy, there is no language regarding patient-centered medical homes. Following the onsite interview, the MCO provided Policy 7000.66 "Patient-Centered Medical Home", which describes the MCO's process for referring members to medical homes, and notes that this is one of the responsibilities of the Care Management program.	
6.38.2.4	Development of an individualized treatment plan, in accordance with Section 6.19.4;	AMA 7500.05 Integrated Care Management LA, page 11.	Full	Pages 11-12 of 7500.05 outline the development of care plans through the case management team.	
6.38.2.5	Referrals and assistance to ensure timely access to providers;	AMA 7500.05 Integrated Care Management LA, page 12.	Full	Page 12 of 7500.05 states "A component of the care planning process includes making referrals for services on the member's behalf…to facilitate timely access to recommended services…"	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community, and other support services where needed;	AMA 7500.05 Integrated Care Management LA, page 7.	Full	Page 7 of 7500.05 has a general statement regarding coordination of care. The requirement is also addressed throughout 7000.43.	
6.38.2.7	Monitoring;	AMA 7500.05 Integrated Care Management LA, page 7.	Full	The requirement is addressed throughout 7500.05, and via the Case Management Reports.	
6.38.2.8	Continuity of care; and	AMA 7500.05 Integrated Care Management LA, page 9.	Full	The requirement is addressed throughout several policies: 7000.43, 7500.05, and 7000.40.	
6.38.2.9	Follow-up and documentation.	AMA 7500.05 Integrated Care Management LA, page 11.	Full	The requirement is addressed throughout several policies: 7000.43, 7500.05, and 7000.40.	
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	AMA 7500.05 Integrated Care Management LA, pages 11-13.	Full	Page 13 of 7500.05 states that care plans are reviewed "at intervals consistent with the member's need for monitoring, the care management stratification level, state requirements…" Following the onsite interview, the MCO provided the Medical	

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	be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.			Management Desktop document, which addresses this requirement throughout.	
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.	AMA 7500.05 Integrated Care Management LA, pages 11-13.	Full	Throughout pages 11-14 of 7500.05, there are general statements about the development and review of care plans focused on member needs, and references to referrals for services on behalf of members. However, there is no documentation in the provided policy that addresses the specificities of this requirement. Following the onsite interview, the MCO provided the Medical Management Desktop document and the IHCM Program Description. Both these documents address the specifics of this requirement in regard to the SHCN populations, including members with behavioral and physical health needs.	
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 and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements;	AMA 7500.05 Integrated Care Management LA, page 1.	Full	There is no documentation in the provided policy that satisfies this requirement. However, during the onsite interview, the MCO provided evidence of correspondence with LDH.	
6.39.1	A process to offer voluntary participation in the Case Management Program to eligible members;	AMA 7500.05 Integrated Care Management LA, page 8.	Full	Page 8 of 7500.05 states that while members are automatically enrolled in care management, they have the opportunity to "opt-out" upon notification of enrollment.	
6.39.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	AMA 7500.05 Integrated Care Management LA, page 5.	Full	Page 5 lists the typical reasons a member would be identified and enrolled for case management.	
6.39.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should	AMA 7500.05 Integrated Care Management LA, page 5.	Full	Page 5 lists the typical reasons a member would be identified and enrolled for case management,	

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	include, but not be limited to, the following: • Reproductive aged women with a history of prior poor birth outcomes; and • High risk pregnant women.			which includes "Members who are pregnant."	
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 within member's treatment providers;	AMA 7500.05 Integrated Care Management LA, page 11.	Full	Policy 7500.05 describes the development of a care plan following completion of the initial evaluation, and that the care plans are developed to address members' needs and are reviewed to determine if members' goals are met. During and after the onsite interview, the MCO provided evidence of the initial assessments conducted for members, which included an assessment of linguistic, religious, and cultural needs the members may have. This assessment is integrated into the development of members' care plans.	
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	AMA 7500.05 Integrated Care Management LA, page 10-11, 13-14.	Full	7500.05 states that assessment of family involvement is a component of the initial assessment and that care plans are shared with the member and/or their representative.	
6.39.6	Procedures and criteria for making referrals to specialists and subspecialists;	AMA 7500.05 Integrated Care Management LA, page 12.	Full	The requirement is addressed on page 12 of 7500.05.	
6.39.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	AMA 7500.05 Integrated Care Management LA, page 13.	Full	Policy 7500.05 only indicates that "the case manager facilitates communication across various disciplines and care settings within and outside the health plan." However, 7000.40 addresses the requirement on pages11-12.	
6.39.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	AMA 7500.05 Integrated Care Management LA, page 11.	Full	The requirement is addressed on page 12 of 7500.05.	
6.40	**Case Management Reporting Requirements**				
6.40	The MCO shall submit case management	PQ039.	Full	The MCO submitted a screenshot of	

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	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:			uploaded quarterly reports for LDH.	
6.40.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	PQ039.	Full	The case management report shows a column for the total number of members identified.	
6.40.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	PQ039.	Full	The case management report contains a tab for the total number of members identified by the PCP/behavioral health provider.	
6.40.3	Number of members identified with potential special healthcare needs that self-refer;	PQ039.	Full	The case management report contains a tab for the total number of members who self-identified as having special healthcare needs.	
6.40.4	Number of members with potential special healthcare needs identified by the MCO;	PQ039.	Full	The case management report contains a tab for the total number of members identified by the plan.	
6.40.5	Number of members in the lock-in program;	RX 165 Lock-in Template	Full	The MCO provided the template for reporting members in the lock-in program.	
6.40.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	317 Level II PASRR Evaluations.	Full	The MCO provided the PASRR report containing the number of members indentified by the PASRR Level II authority.	
6.40.7	Number of members with assessments completed; and	PQ039.	Full	The case management report contains columns for the number of completed assessments within and without the 90 day period, and the rate for compliant assessments.	
6.40.8	Number of members with assessments resulting in a referral for Case Management.	PQ039.	Full	The case management report contains a column for the number of members enrolled in case management resulting from the assessment.	
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;	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Substantial	Page 7 of the policy provided states that it "works with members to address issues related to their asthma, diabetes, heart failure,	

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	Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.			COPD, CAD, depression, and any other condition as required by the state." However, the policy does not address high utilizers of the ED or inpatient services.	
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.	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The MCO includes COPD, and this condition is included in the CCMP report.	
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:	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The MCO has policies and procedures in place. During the onsite interview, the plan provided evidence of correspondence with LDH.	
6.41.4.1	Include the definition of the target population;	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The target population is identified in the *Identification* section of 7500.05.	
6.41.4.2	Include member identification strategies, i.e. through encounter data;	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The requirement is addressed on page 7 of 7500.05.	
6.41.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	While there is no evidence that satisfies this requirement in 7500.05, the ICM Program Description addresses the requirement in full.	
6.41.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, for all program activities and interventions;	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The requirement is addressed on pages 11-14 of 7500.05, as well as in the ICM Program Description.	
6.41.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	AMA 7500.05 Integrated Care Management LA, pages 6-7.	Full	The requirement is addressed in 7500.05 and in the ICM Program Description.	
6.41.4.6	Include methods for informing and educating members and providers;	AMA 7500.05 Integrated Care Management LA, page 8.	Full	Page 8 of 7500.05 states that members and providers are	

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**
				educated through "written materials". It further states that provider educational materials are mailed to providers and are also available on the MCO's website.	
6.41.4.7	Emphasize exacerbation and complication prevention utilizing evidence-based clinical practice guidelines and patients empowerment and activation strategies;	AMA 7500.05 Integrated Care Management LA, page 10.	Full	The requirement is addressed on page 10 of 7500.05.	
6.41.4.8	Address co-morbidities through a whole-person approach;	AMA 7500.05 Integrated Care Management LA, pages 9-10.	Full	The requirement is addressed on page 9 of 7500.05.	
6.41.4.9	Identify members who require in-person case management services and a plan to meet this need;	AMA 7500.05 Integrated Care Management LA, page 6.	Full	Both 7500.05 and the ICM Program Description address in-person case management services for members in Intensive Care Management.	
6.41.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	AMA 7500.05 Integrated Care Management LA, pages 7-8.	Full	The requirement is addressed on page 7 of 7500.05.	
6.41.4.11	Include Program Evaluation requirements.	AMA 7500.05 Integrated Care Management LA, pages 4-5.	Full	The requirement is addressed on page 4 of 7500.05.	
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.	PQ042	Full	The MCO provided a screenshot of uploaded quarterly reports to LDH.	
6.43.2	The CCMP reports shall contain at a minimum:				
6.43.2.1	Total number of members;	PQ042	Full	The CCMP report contains the total numbers of members enrolled in each program for each specific condition.	
6.43.2.2	Number of members in each stratification level for each chronic condition; and	PQ042	Full	The CCMP report contains the total numbers of members in each stratification level for each specific condition.	
6.43.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	PQ042	Full	The CCMP report contains a tab citing the number of disenrolled members and the reason the members were disenrolled.	
6.43.3 6.43.3.1	The MCO shall submit the following report annually: Chronic Care Management Program	PQ042	Full	The CCMP report satisfies this requirement, and the plan provided	

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.			evidence of an annual submission.	

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)]	A-LA 6100.06 Network Adequacy Measurement	Full	During the onsite, the MCO stated that they are comparing provider networks of other payers to see who they can contract with. Providers with subspecialties are currently reported by primary specialties. The MCO is currently working to address the problem. The MCO is attempting to attract providers with incentives to participate such as value based reimbursements. The MCO is limited in terms of how much they can pay providers.	
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.	A-LA 4500.35 Member Rights and Responsibilities	Full	Accessibility aligns with other MCOs in the service area, though not optimal. See GEO Access results noted in this report.	
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)].	Contract language met in A-LA 6100.06 Network Adequacy Measurement	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy Management, page 8.	
7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to	A-LA 6100.06 Network Adequacy Measurement	Full	The requirement is addressed in LA Provider Manual Fall 2016, pages	

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
	all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural 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.	A-LA 6300.10 Provider Responsibilities		30-31.	
7.2	**Appointment Availability Access Standards**				

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
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs 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;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in LA Provider Manual Fall 2016, page 20; and A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring, page 8.	
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;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, pages 38-39; and partially addressed in LA Provider Manual Fall 2016, page 20. Recommendation: While the Member Handbook is fully compliant, the Provider Manual does not state that an appointment should be arranged within 48 hours. Also, the Provider Manual does not mention BH. The MCO should update the provider manual to include the missing language.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, page 39; and in LA Provider Manual Fall 2016, page 20.	
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;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, page 39; and partially addressed in LA Provider Manual Fall 2016, page 20. Recommendation:	

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
				Provider Manual does not mention BH, routine, non-urgent appointments with 14 days. The MCO should update the provider manual to include the missing language.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, page 39; and in LA Provider Manual Fall 2016, page 20.	
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	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, page 39; and in LA Provider Manual Fall 2016, page 20.	
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;	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in Member Handbook, page 41; in LA Provider Manual Fall 2016, page 20; and in A-LA 7000.42 Prenatal Services, page 7.	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in LA Provider Manual Fall 2016, page 20.	
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	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in LA Provider Manual Fall 2016, page 20.	

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
	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 number at all times.				
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.	A-LA 6100.06 Network Adequacy Measurement	Substantial	Not all access standards were met as noted below.	
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	A-LA 6100.06 Network Adequacy Measurement	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 2. The MCO's standard used to analyze compliance with LDH distance/travel standards for Urban PCPs does not match. Urban = 1 provider within 20 miles; the LDH standard is 10 miles. GEO Access Results: **Family/General Practice** Urban = 99.7% with access; 0.3% without access Rural = 100% with access **Pediatrics** Urban = 98.7% with access; 1.3% without access Rural = 97.4% with access; 2.6% without access	

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
				Internal Medicine Urban = 98.3% with access; 1.7% without access Rural = 97.7% with access; 2.3% without access Recommendation: The MCO should update the GEO Access software to ensure analysis is based on the exact standards outlined in the contract.	
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.	Bayou Health Reporting, Network Provider Development Plan,	Substantial	The requirement is addressed in Bayou Health Reporting, Network Provider Development Plan, page 3. The MCO's standard used to analyze compliance with LDH distance/travel standards for Urban Hospitals does not match. Urban = 1 hospital within 20 miles; the LDH standard is 10 miles. GEO Access Results: Urban = 98.8% with access; 1.2% without access Rural = 99.8% with access; 0.2% without access Recommendation: The MCO should update the GEO Access software to ensure analysis is based on the exact standards outlined in the contract.	
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	A-LA 6100.06 Network Adequacy Measurement	Minimal	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 3. The MCO's standard used to analyze compliance with LDH distance/travel standards for specialists is more stringent than LDH standards. For GEO Access analysis, the MCO's standard 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
	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.			urban provider types is 20 miles and the standard for rural provider is 30 miles. Geo-Access Report Results **Allergy/Immunology** Urban = 94.0% with access; 6.0% without access Rural = 48.6% with access; 51.4% without access **Anesthesiology** Urban = 96.5% with access; 3.5% without access Rural = 90.5% with access; 9.5% without access **Audiology** Urban = 88.2% with access; 11.8% without access Rural = 54.1% with access; 45.9% without access **Cardiology** Urban = 97.6% with access; 2.4% without access Rural = 91.8% with access; 8.2% without access **Chiropractic** Urban = 84.3% with access;15.7% without access Rural = 63.8% with access; 36.2% without access **Dermatology** Urban = 86.9% with access; 13.1% without access Rural = 52.9% with access; 47.1% without access **Emergency Medicine** Urban = 98.8% with access; 1.2%	

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
				without access Rural = 97.8% with access; 2.2% without access **Endocrinology and Metabolism** Urban = 77.3% with access; 22.7% without access Rural = 37.7% with access; 62.3% without access **Gastroenterology** Urban = 90.4% with access; 9.6% without access Rural = 55.4% with access; 44.6% without access **Hematology/Oncology** Urban = 95.3% with access; 4.7% without access Rural = 62.8% with access; 37.2% without access **Hospice** Urban = 89.8% with access; 10.2% without access Rural = 86.7% with access; 13.3% without access **Infectious Disease** Urban = 93.5% with access; 6.5% without access Rural = 56.6% with access; 43.4% without access **Neonatology** Urban = 81.8% with access; 18.2% without access Rural = 42.4% with access; 57.6% without access **Nephrology** Urban = 94.4% with access; 5.6% without access	

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
				Rural = 64.2% with access; 35.8% without access **Neurology** Urban = 96.2% with access; 3.8% without access Rural = 63.1% with access; 36.9% without access **Nuclear Medicine** Urban = 80.4% with access; 19.6% without access Rural = 43.5% with access; 56.5% without access **OB/GYN** Urban = 98.7% with access; 1.3% without access Rural = 90.5% with access; 9.5% without access **Occupational Therapy** Urban = 81.5% with access; 18.5% without access Rural = 58.7% with access; 41.3% without access **Ophthalmology** Urban = 96.8% with access; 3.2% without access Rural = 76.8% with access; 23.2% without access **Optician/Optometry** Urban = 98.5% with access; 1.5% without access Rural = 99.5% with access; 0.5% without access **Orthopedics** Urban = 95.1% with access; 4.9% without access Rural = 85.4% with access; 14.6%	

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 **Otolaryngology** Urban = 91.9% with access; 8.1% without access Rural = 79.3% with access; 20.7% without access **Pathology** Urban = 89.7% with access; 10.3% without access Rural = 51.3% with access; 48.7% without access **Pediatric Allergy** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Pediatric Cardiology** Urban = 90.0% with access; 10.0% without access Rural = 49.2% with access; 50.8% without access **Personal Care Services** Urban = 80.6% with access; 19.4% without access Rural = 57.8% with access; 42.2% without access **Podiatry** Urban = 97.1% with access; 2.9% without access Rural = 79.5% with access; 20.5% without access **Pulmonary Medicine** Urban = 94.1% with access; 5.9% without access Rural = 59.9% with access; 40.1% without access	

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
				Radiology - Diagnostic Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Radiology - Therapeutic** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Rheumatology** Urban = 88.4% with access; 11.6% without access Rural = 37.5% with access; 62.5% without access **Speech Therapy** Urban = 79.5% with access; 20.5% without access Rural = 48.9% with access; 51.1% without access **Surgery Cardiovascular** Urban = 97.6% with access; 2.4% without access Rural = 91.8% with access; 8.2% without access **Surgery – Colon & Rectal** Urban = 0% with access; 100% without access Rural = 0% with access; 100% without access **Surgery – General** Urban = 97.4% with access; 2.6% without access Rural = 94.7% with access; 5.3% without access	

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
				Surgery – Neurological Urban = 80.3% with access; 19.7% without access Rural = 23.2% with access; 76.8% without access **Surgery – Pediatric** Urban = 71.1% with access; 28.9% without access Rural = 10.7% with access; 89.3% without access **Surgery – Plastic** Urban = 80.4% with access; 28.9% without access Rural = 29.5% with access; 70.5% without access **Surgery – Thoracic** Urban = 93.8% with access; 6.2% without access Rural = 61.6% with access; 38.4% without access **Urology** Urban = 94.8% with access; 5.2% without access Rural = 76.7% with access; 23.3% without access	
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.	Bayou Health Reporting, Network Provider Development Plan,	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. Standard in Geo Access Reports matches LDH requirements. <u>Geo-Access Report Results</u> Urban = 96.6% with access; 3.4% without access Rural = 86.6% with access; 13.4% without access	
7.3.5 7.3.5.1	Pharmacies • Travel distance shall not exceed 20 miles in	Bayou Health Reporting, Network Provider	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy	

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
7.3.5.2	urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	Development Plan,		Measurement, page 5. MCO requirement for Urban is 10 miles. Standard in Geo Access Reports matches LDH requirements. Geo-Access Report Results Urban = 99.5% with access; 0.5% without access Rural = 100% with access; 0% without 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.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
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 in rural parishes shall not exceed 30 miles for 90% of such members.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access Results: **Outpatient Therapy** Rural: 99.8% with access; 0.2% without access	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access Results: **Outpatient Therapy** Urban: 97.1% with access; 2.9% without access	
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.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring	Bayou Health Reporting, Network Provider	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy	

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
	treatment shall not exceed 60 miles for 90% of adult members.	Development Plan		Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access reports for this specialty type were not available for review or confirmation.	
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	Bayou Health Reporting, Network Provider Development Plan	Substantial	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5. GEO Access Results: **Psychiatric Residential Treatment Facilities** Urban: 46.4% with access; 53.6% without access Standard used is 1 provider within 15 miles. Rural: 9.3% with access; 90.7% without access. Standard used is 1 provider within 30 miles.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in A-LA 6100.06 Network Adequacy Measurement, page 5.	
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.		Full	MCO Onsite Comment: If the member chooses to go out of network, we cannot control that or the power to enforce anything.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is address in Bayou Health Reporting, Network Provider Development Plan, page 4.	

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**
7.5	**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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in LA Provider Manual Fall 2016, pages 20-21; in Member Handbook, page 39. During the onsite, the MCO stated that they conduct appointment availability surveys, "secret shopper survey." After hours assessments are in scope.	
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 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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting Network Provider Development Plan. GEO Access reports that were reviewed included the appropriate elements outlined in the requirement.	
7.5.3 7.5.3.1	**Provider to Member Ratios** Quarterly GeoAccess reports shall include	Bayou Health Reporting, Network Provider	Full	The requirement is addressed in GEO Access ABG 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
7.5.3.2	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.	Development Management Plan			
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 pre-tenancy supports for the Louisiana Permanent Supportive Housing program.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is partially addressed in Bayou Health Reporting Network Provider Development Management Plan, pages 1, and 8-9. During the onsite, the MCO stated that they have contracts with family planning clinics and providers – they receive provider referrals and reach out to providers. The MCO does contract with PSH.	
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	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is Bayou Health Specialized Behavioral Health Network Development and Management addressed in, pages 1-2.	

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
	(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).			–	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 3.	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 1-2.	
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	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 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
	specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].				
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 its decision [42 CFR 438.12(a)(1)].	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 2.	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	This requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 2.	
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.	Bayou Health Reporting, Network Provider Development Management Plan LA- Credentialing Policy Amendments: - LA- QM 53 - LA- QM 54 - LA- QM 70 * Located in Quality Management section Aetna Standard Credentialing Policies - QM 53 - QM 54 - QM 70 * Located in Quality Management section	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 2.	
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	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 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
	CFR 438.214(c)].				
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 2; and in LA Provider Manual Fall 2016, page 32.	
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.	Louisiana Medicaid Compliance Addendum	Full	The requirement is addressed in 6100.90 Provider Network Voluntary and Involuntary Termination, pages 3-4.	
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).	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in 6100.90 Provider Network Voluntary and Involuntary Termination, page 5.	
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.	A-LA 6300.10 Provider Responsibilities	Full	The requirement is addressed in the Medicaid Compliance Addendum, page 16.	
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:	Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in LA Provider Manual Fall 2016, page 30; and in ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
7.7.2.1	Denying or not providing to a member any	6300.10 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
	covered service or availability of a facility.	Responsibilities *Located in Provider Services section		ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	6300.10 Provider Responsibilities *Located in Provider Services section	Full	This requirement is addressed in ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
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.	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
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	Bayou Health Specialized Behavioral Health Network Development	Full	During the onsite, the MCO stated that they have not had an occurrence where a provider was found to be non compliant with mainstreaming.	
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.	Bayou Health Specialized Behavioral Health Network Development	Full	The requirement is addressed in ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
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;	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 11.	
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;	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 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
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 11.	
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;	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, pages 6 and 11.	
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;	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, pages 4 and 11.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 11.	
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.	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 11.	
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.	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 11.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Louisiana Medicaid Compliance Addendum	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 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
		6300.10 Provider Responsibilities			
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.		Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 4.	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	A-LA 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 4.	
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.	Louisiana Provider Manual Fall 2016	Full	The requirement is addressed in Louisiana Provider Manual Fall 2016, page 45.	
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).	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 7.	
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 7; and in A-LA 7000.42 Prenatal Services, page 4-5.	
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	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, 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
	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				
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is address in Bayou Health Network Provider Development Management Plan, pages 7-8. During the onsite, the MCO stated that they never had a requirement to have higher ratios or to include additional provider types.	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Member Handbook, page 26 and 44. During the onsite, the MCO stated that members do not need referrals to see specialists.	
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. 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.	A-LA 6100.45 Network Development, Composition, Adequacy Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Network Provider Development Management Plan, page 8. Language was not found that addresses the requirement of one hospital that provides ER services, inpatient, and outpatient care in each parish; Level III OB services; Pediatric Services, and Children's Hospital that meets CMS definition. During the onsite, the MCO stated that the requirement is addressed	

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
				in GEO Access reports. Plan agreed with suggestion to list these specific services in the network development plan.	
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	A-LA 6100.06 Network Adequacy Measurement	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 12.	
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.	A-LA 6100.06 Network Adequacy Measurement	Full	During the onsite, the MCO stated that they are currently contracting with out of state border hospitals. MCO will send list of border hospitals. The MCO shared the list of border hospitals. Hospitals were located in AR, TN, TX and MS.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 8.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 9.	
7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use	LA Bayou Health Member Handbook	Full	The requirement is addressed in Member Handbook, pages 28, 33-	

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
	their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. 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.			34, and 56; and in A-LA 8300.20 Family Planning_Reproductive Health 2016, page 5.	
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.	A-LA- 8300.20 Family Planning Reproductive Health	Full	The requirement is addressed in Member Handbook, page 28; and in A-LA 8300.20 Family Planning_Reproductive Health 2016, page 8.	
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.	LA- 8300.20 Family Planning Reproductive Health	Full	The requirement is addressed in A-LA 8300.20 Family Planning_Reproductive Health 2016, page 4.	
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	7000.42 Prenatal Services LA	Full	The requirement is addressed in the Member Handbook, page 35; and in A-LA 7000.42 Prenatal Services, page 1. However, the Member Handbook does not inform members that a PCP will be chosen	

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
	member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.			for the newborn if the mother does not select one within 14 days of birth. Recommendation: Consider updating the member handbook to inform the member that a PCP will be chosen for a newborn within 14 days if the mother does not select a PCP.	
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.		Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 8.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 1, and 7-8.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 7-8.	
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the 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).	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 7-8.	
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		Substantial	The MCO did not provide evidence of coordination with OBH. Such evidence may include shared policies, memos or MOUs.	

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
	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.			MCO: We coordinate whatever our public health initiatives are. We have never had to contact OPH to coordinate public health activities.	
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.	Louisiana Provider Manual Fall 2016	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development.	
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).	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 6.	
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 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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 6.	
7.8.14.7	The MCO shall have a fully operational network of behavioral health crisis response	Bayou Health Specialized Behavioral Health Network	Full	The requirement is partially addressed in Bayou Health	

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 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.	Development		Specialized Behavioral Health Network Development, page 3 and 6-7. During the onsite, the MCO stated that Crisis stabilization is new. Fidelity Monitoring Program, FFT, Homebuilders, ACT – members in crisis situations can use these resources.	
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.	Bayou Health Specialized Behavioral Health Network Development	Full	The requirement is addressed in Louisiana Medicaid Compliance Addendum, page 20. During the onsite, the MCO presented a Best Practice - the standard assessment form that any provider might use where they obtain information about health issues and who the provider of their health services may be. This determines if there needs to be coordination of care, There are specific legal requirements in LA where BH providers must coordinate with the prescriber. Many providers 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
				children services and adult services use forms that were developed by the State, such as 1915C form which is used to determine eligibility for coordination of care. Adult services providers use 1915C which is geared towards to adults and allows for the medical coordination and the identification of SPMI members.	
7.9	**Bayou Health Reporting, Network Provider Development 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 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):	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan.	
7.9.1.1	Anticipated maximum number of Medicaid members;	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 4.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 3-4.	
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;	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 16.	

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
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 6-7.	
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.	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 4.	
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:	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, and addressed in Bayou Health Specialized Behavioral Health Network Development.	
7.9.2.1	Assurance of Adequate Capacity and Services	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Provider Network Development and Management Plan.	
7.9.2.2	Access to Primary Care Providers	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Provider Network Development and Management Plan, page 6.	
7.9.2.3	Access to Specialists	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Provider Network Development and Management Plan, page 7.	
7.9.2.4	Access to Hospitals	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Provider Network Development and Management Plan, page 8.	
7.9.2.5	Access to Behavioral Health Services	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development.	
7.9.2.67	Timely Access	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 1.	
7.9.2.7	Service Area	Bayou Health Reporting,	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
		Provider Network Development and Management Plan		Bayou Health Reporting, Network Provider Development Management Plan, page 9.	
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	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 9.	
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.	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 2-3.	
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.	Bayou Health Reporting, Provider Network Development and Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 13.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:				
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 14.	
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;	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 14-15.	
7.9.5.3	Evaluate the quality of services delivered by the network;	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 15-16.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become	Bayou Health Reporting, Network Provider	Full	The requirement is addressed in Bayou Health Reporting, Network	

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
	temporarily insufficient within the contracted service area;	Development Management Plan		Provider Development Management Plan, page 16.	
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	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 16. Recommendation: The MCO should consider including language to address provision of care to members with limited proficiency in English.	
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;	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is partially addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 16 Addressed in A-LA QM 75 Credentialing Policy and Procedure Development Amendment 2016; and addressed in AMA 8100.32 Non-Traditional Provider Credentialing CORPORATE USE ONLY. During the onsite, the MCO stated that their CBO does not allow for expedited and temporary credentials.	
7.9.5.7	Provide training for its providers and maintain records of such training;	Bayou Health Reporting, Network Provider Development Management Plan A-LA 6200.15 Provider Relations Department Functions and Responsibilities	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 16-17.	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and	Bayou Health Reporting, Network Provider Development Management	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development	

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
	appropriate;	Plan A-LA 6300.35 Provider Grievance LA		Management Plan, pages 17-18.	
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.	6300.35 Provider Grievance LA	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 18.	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 21.	
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.	Bayou Health Reporting, Network Provider Development Management Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, page 18.	
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.	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 1.	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral	Bayou Health Specialized Behavioral Health Network Development and	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development 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
	health services for both children and adults, and satisfy all service delivery requirements described in this contract	Management		Management, pages 1-2. The specific BH provider types are listed. Recommendation: In the future, the MCO should incorporate the BH network development plan into the MCO's overall network development plan.	
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;	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 4.	
	• 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);	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 4-5.	
	• 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 quarterly by contract year, upon material change of the network, or upon request;	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 5-6.	
	• 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;	Bayou Health Specialized Behavioral Health Network Development and Management	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 6. The language in the referenced document does not specifically state the elements required.	

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
	• 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.			During the onsite, the MCO stated that they conduct assessments on a monthly basis using GEO Access reports. Providers who are being offered single case agreements are also being offered contracts to join the network. All of these elements are being used to support network development. Recommendation: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	
	• 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 with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.	Network Provider Development Plan A-LA 6100.45 Network Development Compositions, Adequacy, Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 6-7. The language in the referenced document does not specifically state the elements required. Recommendation: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	
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,	A-LA 6100.45 Network Development Compositions, Adequacy, Access Standards &	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development 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
	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.	System Monitoring, page 17		Management, pages 7-11.	
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; • 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	Network Provider Development Plan	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 8. The language in the referenced document does not specifically state the elements required. During the onsite, the MCO stated that they will update development plan to include all elements. Recommendation: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	

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
	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.	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 8. The language in the referenced document does not specifically state the elements required. During the onsite, the MCO stated that they will update development plan to include all elements. Recommendation: Update Bayou Health Specialized Behavioral Health Network Development and Management document to address this contract requirement in its entirety.	
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,	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Substantial	The requirement is partially addressed in Bayou Health Specialized Behavioral Health Network Development and Management, pages 8-10. The referenced document does not include provider requirement for annual training, the sharing of provider satisfaction results, etc. During the onsite, the MCO stated	

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 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.			that they will update Provider Manual and send the auditor the updated version. The MCO is in the process of concluding the 1st provider satisfaction survey. Results will be shared with providers. The MCO submitted a revised Provider Manual that includes language regarding annual training.	
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and 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	Bayou Health Reporting, Network Provider Development Plan	Substantial	The Bayou Health Reporting Network Provider Development Plan includes language regarding MCO steps for monitoring and evaluating network development and management plan and policy and procedures, however, it does not clearly state whether or not the	

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
	behavioral healthcare.			results of monitoring and evaluation activities would be included in subsequent network development reports. Recommendation: Update Bayou Health Reporting Network Provider Development Plan to include a specific section for the evaluation of the previous year's network development plan.	
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.	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring, page 3. This document addresses the 7 day notification timeframe, but it does not include a description of what a material change is. A description of material change can be found in Bayou Health Reporting Network Development Plan, page 10. During the onsite, the MCO stated that they will update policy (A-LA 6100.45) to include the definition of material change.	

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
7.11.2	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, payments, or eligibility of a new population.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 10.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 10.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 10.	
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	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Management Plan, pages 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
	change is likely to affect the delivery of covered services.				
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 exempt from this requirement.	Louisiana Medicaid Compliance Addendum, Exhibit A	Full	The requirement is addressed in ABH LA Medicaid Compliance Addendum Provider Exhibit A V.5.12.2016, page 16.	
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.	A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring	Full	The requirement is addressed in A-LA 6100.45 Network Development, Composition, Adequacy, Access Standards & System Monitoring, page 3. The referenced document mentions the 7 day notification timeframe; it does not include a description of what BH material change is. During the onsite, the MCO stated that they will update policy to include definition of material change.	
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.	Bayou Health Reporting, Network Provider Development Plan	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Plan, page 9.	
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		Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Plan, page 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
	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: • 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.	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Reporting, Network Provider Development Plan, page 9.	
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-	Bayou Health Specialized Behavioral Health Network Development and Management	Full	The requirement is addressed in Bayou Health Specialized Behavioral Health Network Development and Management, page 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
	engage persons who miss their first appointment with the new provider).				
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 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).	AMA 7000.43 Coordination of Member Care LA *Located in Core Benefits and Services section	Full	The requirement is met in AMA 7000.43 Coordination of Member Care LA, page 2.	
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.	LA- Credentialing Policy Amendments: - LA- QM 53 - LA- QM 54 Aetna Standard Credentialing Policies - QM 53 - QM 54	Full	The requirement is addressed in A-LA QM 54 Practitioner Credentialing Recredentialing, page 3.	
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.	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70 -LA – QM 75 -LA – QM 78	Full	The requirement is addressed in A-LA QM 54 Practitioner Credentialing Recredentialing, pages 1-2.	

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
7.14.1.1	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 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).	LA – 8100.32 LA – 8100.32A	Not Met	Language is not found in referenced document. Post Onsite: MCO submitted a revised LA – 8100.32A which includes the language in this requirement, making the MCO fully compliant but the change was made after the review period and after the onsite visit.	
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.	LA – QM 56	Full	The requirement is addressed in A-LA QM 56 Practitioner Application, page 2.	
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.	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70 -LA – QM 75 -LA – QM 78	Full	The requirement is addressed in A-LA QM 54 Practitioner Credentialing Recredentialing, page 2.	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70	Full	The requirement is addressed in A-LA QM 54 Practitioner Credentialing Recredentialing, page 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
		-LA – QM 75 -LA – QM 78			
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:	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70 -LA – QM 75 -LA – QM 78	Full	The requirement is addressed in A-LA QM 56 Practitioner Application, page 2. MCO policy states 30 calendar days to complete the process.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70 -LA – QM 75 -LA – QM 78	Full	The requirement is addressed in A-LA QM 56 Practitioner Application, page 2.	
7.14.5.2	Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or	LA 6100.45 Network Development, Composition, Adequacy Access Standards & System Monitoring	Full	The requirement is addressed in A-LA QM 56 Practitioner Application, page 2.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	LA- Credentialing Policy /Amendments: - LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62 -LA – QM 70 -LA – QM 75 -LA – QM 78	Full	The requirement is addressed in A-LA QM 56 Practitioner Application, page 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
7.14..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.	LA – 8000.60	Full	The requirement is addressed in A-LA 800.60 Delegation Oversight Responsibilities.	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.	LA – 8100.32 LA – 8100.32A	Full	During the onsite, the MCO stated that they only delegate credentialing to facilities. NCQA requirements were met.	
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.	LA – QM 70	Full	The requirement is addressed in A-LA QM 70 Medical Director Cred_Recred_Peer Review Amendment, page 2.	
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.	LA – 6100.90	Full	The requirement is addressed in Bayou Health Reporting Network Provider Development Plan, page 11; addressed in A-LA QM 54 Practitioner Credentialing Recredentialing; and addressed in A-LA QM 62 Practitioner Participation and Peer Review.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	LA – QM 54 LA – QM 59	Full	The requirement is addressed in A-LA QM 70 Medical Director Cred_Recred_Peer Review Amendment, page 3.	
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.	LA – 6100.90 LA – 8100.32 LA – 8100.32A LA QM 51 -LA- QM 53 - LA- QM 54 -LA – QM 56 -LA - QM 59 -LA – QM 62	Full	The requirement is addressed in A-LA QM 54 and A-LA QM 62.	

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
		-LA – QM 70 -LA – QM 75 -LA – QM 78			
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.	LA – 6100.90 LA – QM 63	Full	The requirement is addressed in A-LA QM 62, pages 2-3.	
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.	8000.15	Full	The requirement is addressed in A-LA QM 62, pages 2-3.	
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 §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:	Louisiana Medicaid Compliance Addendum 6300.10 Provider Responsibilities	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	

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
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	
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.	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	
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.	6300.10 Provider Responsibilities *Located in Provider Services section	Full	The requirement is addressed in A-LA 6300.10 Provider Responsibilities, page 13.	

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.	A-LA 7100.05 Prior Authorization Reporting – p 21 and Decision/Notification Requirements pp 14 – 15 Decision/Notification Time Standards P 12 A-LA 7200.05 Concurrent Review: Inpatient QM/UM Committee Agenda Exhibit 1 QM/UM Minutes 7.20.2016 – Exhibit 2	Substantial	All deficiencies in UM policies and procedures were discussed onsite with the MCO, which provided additional information post-onsite where noted below. The MCO explained onsite that some Louisiana contract specific language had been removed from some policies and procedures by the Corporate office. The MCO stated that any deficient P/Ps will be amended to include Louisiana specific contract language. Recommendation: The MCO should amend relevant P/Ps to include Louisiana specific contract language as required for compliance with the Louisiana State contract.	
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;	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Definitions pp 1-3 Aetna Better Health Responsibilities pp 3-4	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Definitions, pgs. 1- 4.	
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;	A-LA 7000.30 Process for Approving and Applying Medical necessity Criteria A-LA 7100.05 Prior Authorization	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria, and in the P/P A-LA 7100.05 Prior Authorization.	
8.1.2.3	Are considerate of the needs of the members; and	A-LA 7000.30 Process for Approving and Applying Medical necessity Criteria p. 4 A-LA 7100.05 Prior Authorization	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical necessity Criteria p.3-4.	

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
		Extension of Decision Timeframes for Non-urgent Pre-Service Decisions pp 15-16 Extension of Timeframes for Urgent Pre-Service Decisions pp16-17 Extension of Timeframes for Urgent Concurrent Decisions pp 17-18			
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	A-LA 7000.30 Process for Approving and Applying Medical necessity Criteria	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical necessity Criteria, effective2-1-15 and reviewed and revised 3-2016.	
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;	2016 UM Program Description Performance Monitoring pp 25-26 A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Operating Protocol pp 4 - 5	Full	The requirement is met in the 2016 UM Program Description pgs. 25-26 and in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Operating Protocol pp. 4 – 5.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	2016 UM Program Description Prior Authorization pp 19-20 Performance Monitoring pp 25- 26, and pg 28 has IRR reference. Post-onsite: the P/PA-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Reporting	Full	The requirement is met in the P/PA-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Reporting and is also addressed in the 2016 UM Program Description.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	2016 UM Program Description19 – 20 A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria	Full	The 2016 UM Program Description19 – 20 has required language. This requirement is also met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Reporting pg. 6	

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
		Reporting p 6		which states required language for documenting all meeting minutes related to UM.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	2016 UM Program Description Peer to Peer Consultation pp 22 - 23	Full	The requirement is met in the 2016 UM Program Description Peer to Peer Consultation pp. 22 – 23.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	2016 UM Program Description Under and Over Utilization pgs. 26-29. Post-onsite: P/PA-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria	Full	The requirement is met in the 2016 UM Program Description, Under and Over Utilization pgs. 26-29, and in the P/PA-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Reporting.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	2016 UM Program Description Improvement Indicators pp 27 - 28	Full	The requirement is met in the 2016 UM Program Description Improvement Indicators pp. 27 – 28.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	2016 UM Program Description Confidentiality/Conflict of Interest pp 33 - 34	Full	The requirement is met in the 2016 UM Program Description Confidentiality/Conflict of Interest pp. 33 – 34.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	2016 UM Program Description Medical Necessity Criteria pp 16 - 17	Full	This requirement is met in the 2016 UM Program Description Medical Necessity Criteria pp. 16 – 17.	
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;	Pre-onsite: 2016 UM Program Description Discharge Planning p 22 Post-onsite: A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4	Substantial	Prior to the onsite, contract language was not found in 2016 UM Program Description, Discharge Planning p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. Recommendation: The MCO has updated the referenced policy to meet 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	2016 UM Program Description p 22	Substantial	Prior to the onsite, the Contract language was not found in 2016 UM Program Description p. 22.	

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
	of behavioral health services and medication prior to reentry into the community, including referral to community providers;	A-LA 7000.43 Coordination of Member Care p 4		Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. Recommendation: The MCO has updated the referenced policy to meet this 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	2016 UM Program Description p 22 Post-onsite: A-LA 7000.43 Coordination of Member Care p. 4	Substantial	The contract language was not found in the 2016 UM Program Description p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. Recommendation: The MCO has updated the referenced policy to meet this 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.	2016 UM Program Description p 22 A-LA 7000.43 Coordination of Member Care p 4	Substantial	The contract language was not found in the 2016 UM Program Description p. 22. Post-onsite, the MCO updated the Policy A-LA 7000.43 Coordination of Member Care Responsibilities pg. 4 to include the contract language. Recommendation: The MCO has updated the referenced policy to meet this requirement.	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Pre-onsite: A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria Definitions pp 1 - 3 Responsibilities pp 3 – 4 Post-Onsite: PIP submission	Full	The Policy A-LA 7000.30 addresses this issue, but not the specific requirement that MCOs coordinate CPGs to avoid conflicting practice guidelines. Post-onsite, the Policy _A-LA QM 65 Clinical Practice and Preventive Services Amendment addresses CPG	

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 _A-LA QM 65 Clinical Practice and Preventive Services Amendment		development, and the collaborative PIPs address MCO collaboration for CPGs for the PIP topics. Recommendation: The requirement language should be incorporated into a P/P for UM, for guideline development coordination, or for guideline research, selection, adoption, review, update, & update schedule. The MCO should clarify with LDH whether this requirement applies to all CPGs, or only those associated with the PIP topics.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	2016 UM Program Description P. 16	Full	The requirement is met in the 2016 UM Program Description p. 16.	
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.	Pre-onsite: 2016 UM Program Description Medical Necessity Criteria PP 16-17 A-LA 8000.50 Pay for Quality Focus/Disposition pp 2-3 Post-onsite: A-LA 7000.30 Approval Process of Medical Necessity Criteria ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016, pg. 21	Substantial	Prior to the onsite, the contract language was not found in either submitted document, and provider contracts were not submitted for review. The compliance report, (069) UM Medical Record Review Summary Rpt_ 10302015 - 8.13.0, provides evidence of implementation of this requirement. Post-onsite, the MCO updated the Policy A-LA 7000.30 Approval Process of Medical Necessity Criteria to include the contract language, and submitted the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016, pg. 21. Recommendation: The MCO updated the Policy A-LA 7000.30 Approval Process of Medical Necessity Criteria to include the contract language, and	

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
				submitted the template provider contract ABH LA Medicaid Compliance Addendum Provider, pg. 21, to meet compliance with the addition of the compliance report, (069) UM Medical Record Review Summary Rpt_ 10302015 - 8.13.0.	
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:	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria P 2 p 5	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria p. 2, p. 5.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria P 2 p 5	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria p. 2, p. 5.	
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;	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria P 2 p 5	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria p. 2, p. 5.	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria P 2 p 5	Full	The requirement is met in the P/P A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria p. 2, p. 5.	
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.	A-LA 7200.05 Concurrent Review: Inpatient ,pg. 4, pg. 10 A-LA 7100.05 Prior Authorization p 9	Full	The requirement is met in the P/P A-LA 7200.05 Concurrent Review: Inpatient, pg. 4, pg. 10, and A-LA 7100.05 Prior Authorization p. 9.	
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.	A-LA 7100.05 Prior Authorization pp 2 - 3 p 13	Substantial	Prior to onsite the language, "Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines" was not found in the submitted document.	

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 updated the policy A-LA 7100.05 Prior Authorization p. 17 to include the required language. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization p. 17 to include the required language which meets the requirement.	
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.	A-LA 7100.05 Prior Authorization p 5, pp 11 - 12	Substantial	Prior to the onsite, the full contract language was not found in the submitted policy. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization pgs. 15-16 to include the required language. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization pgs. 15-16 to include the required language which meets the requirement.	
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.	A-LA 7100.05 Prior Authorization, pg. 12 A-LA 7200.05 Concurrent Review: Inpatient pp 8 - 9	Substantial	Prior to the onsite the contract language was not found in either submitted policy. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization pg. 17 to include the required language. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization pg. 17 to include the required language which meets 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	2016 UM Program Description P 12 – 13 A-LA 7200.05 Concurrent Review: Inpatient P 10	Substantial	Prior to the onsite, all required language was not found in the submitted documents; a staffing plan was not submitted for review. Post-onsite, the MCO updated the	

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
	PSH to ensure appropriate authorization of tenancy services.	A-LA 7100.05 Prior Authorization P 12 Post-onsite: Org.Chart A-LA 7100.05 Prior Authorization pg. 16		policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language, and submitted an organization UM staffing chart. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language, and also submitted an UM staffing chart which meets the requirement.	
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.	A-LA 7000.30 Process for Approving and Applying Medical Necessity Criteria P 4 A-LA 7200.05 Concurrent Review: Inpatient P 4 A-LA 7100.05 Prior Authorization P 5 Post-onsite: UM Program Description, pg. 13.	Full	The contract language was not found in the submitted policies, but was met on pg. 13 of the UM Program Description. Post-onsite, the MCO added the required language to A-LA 7100.05 Prior Authorization.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite the MCO did not submit a staffing plan. Post-onsite, the MCO updated the policy A-LA 7100.05 Prior Authorization and submitted an organization UM staffing chart. Recommendation: The MCO updated the policy A-LA 7100.05 Prior Authorization and also submitted an UM staffing chart to meet the requirement.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	AMA 7100.05 Prior Authorization LA, pg. 9	Full	This requirement is met in the P/P AMA 7100.05 Prior Authorization LA, pg. 9, which states "in accordance with state and federal regulations."	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical	AMA 7100.05 Prior Authorization LA, pg. 9	Full	The P/P AMA 7100.05 Prior Authorization LA, pg. 9, meets this	

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
	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.	A-LA 7200.05 Concurrent Review: Inpatient, pg. 6		requirement. File Review Results: Nine (9) of the ten (10) UM denial files reviewed onsite required clinical expertise and all nine (9) 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.	A-LA 7000.08 Clinical Personnel License Requirements PP 1-2 Post-onsite: A-LA 7100.05 Prior Authorization pg. 16	Substantial	Prior to the onsite, the P/P A-LA 7000.08 was not submitted for review. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 16 to include the required language.	
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.	2016 UM Program Description P 13 A-LA 7000.08 Clinical Personnel License Requirements P 13 Post-onsite: A-LA 7100.05 Prior Authorization pg. 16	Substantial	Prior to the onsite, the requirement was not met in the 2016 Program Description, and as noted above, the P/P A-LA 7000.08 Clinical Personnel License Requirements pg. 13 was not submitted for review. Post-onsite, the policy A-LA 7100.05 Prior Authorization pg. 16 was revised to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 16 to include required language, meeting the requirement.	
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	A-LA 7500.05 Integrated Care Management P 13 A-LA 7000.40 Member Transition P 5	Substantial	Prior to the onsite, the required language was not found in P/Ps 7500.05 or A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the	

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
	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.	Post-onsite: A-LA 7100.05 Prior Authorization pgs. 16-17		policy A-LA 7100.05 Prior Authorization pgs. 16-17, to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 16-17 to include required language, meeting the requirement.	
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.	2016 UM Program Description P 16	Full	The requirement is met in the 2016 UM Program Description pg. 16.	
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	A-LA 7100.05 Prior Authorization pp 4, 6 pp 10 A-LA 7200.05 Concurrent Review: Inpatient p 9 - 10 Definitions pp 2 - 5	Full	The requirement is met in the P/P A-LA 7100.05 Prior Authorization pp. 4, 6, and 10.	
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:	A-LA 7100.05 Prior Authorization pp 4, 6 pp 10	Full	The requirement is met in the P/P A-LA 7100.05 Prior Authorization pp. 4, 6, and 10.	

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
8.4.2.1	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;	A-LA 7100.05 Prior Authorization p 10	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization pg. 10. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 11, to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pgs. 11 to include required language, meeting the requirement.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	A-LA 7100.05 Prior Authorization P 12 A-LA 7200.05 Concurrent Review: Inpatient P 10 2016 UM PD, pg. 29	Full	The mechanism of IRR is not fully stated in either submitted policy which also reference the policy 7000.30 Process for Approving and Applying Medical Necessity Criteria (provided for another element, but which also does not reference the language). The 2016 UM Program Description Utilization Management Monitoring and Reporting pg. 29 was found to meet 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;	A-LA 7100.05 Prior Authorization P 10 A-LA 7200.05 Concurrent Review: Inpatient p 7	Full	The requirement in met in both P/Ps A-LA 7100.05 Prior Authorization pg. 10, and A-LA 7200.05 Concurrent Review: Inpatient pg. 7.	
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;	A-LA 7100.05 Prior Authorization P 8	Full	The required language is found in the member handbook pg. 30 and is addressed in the policy A-LA 7100.05 Prior Authorization pg. 8.	
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-	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite, the element language: "and effective dates for authorization to participating providers and applicable non-	

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
	participating providers; and			participating providers" was not found in A-LA 7100.05 Prior Authorization pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language, meeting the requirement.	
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.	A-LA 7100.05 Prior Authorization P 9	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization pg. 15 to include the required language, meeting the requirement.	
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.	A-LA 7100.05 Prior Authorization P 5 2016 UM Program Description P 17 Post-onsite: A-LA 7200.05 Concurrent Review Inpatient	Substantial	The contract language not found in either policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review Inpatient to include the required language. Recommendation: The MCO revised the policy A-LA 7200.05 Concurrent Review Inpatient pg. 13 to include the required language, meeting the 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
8.4.4	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.	A-LA 7100.05 Prior Authorization PP 9-11 PP 5-7 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	The contract language was not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2) pg. 10 to include the required language, meeting the requirement.	
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].	A-LA 7200.05 Concurrent Review: Inpatient pg. 10 Post onsite: A-LA 7200.05 Concurrent Review: Inpatient pg. 6	Substantial	The contract language not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient, pg. 6 to include the required language. Recommendation: The MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient pg. 6 to include the required language, meeting the requirement.	
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.	A-LA 7200.05 Concurrent Review: Inpatient pgs. 9-10 Post onsite: A-LA 7200.05 Concurrent Review: Inpatient pgs. 4-5	Substantial	The contract language not found in the policy submitted prior to the onsite. Post onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient, pgs. 4-5 to include the required language. Recommendation: The MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient pgs. 4-5 to include the required language, meeting the 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
8.4.4.3	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 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	A-LA 7200.05 Concurrent Review: Inpatient Definitions pp 2-5 Behavioral Health Admissions and Treatment PP 8-9 Definitions PP 11-12 Decisions/Notification Time Standards PP 11-12 Definitions PP 2-6 Emergency P 5 Urgent P 6	Substantial	The element language was not found in the policy A-LA 7200.05 Concurrent Review: Inpatient Definitions pgs. 2-12, prior to the onsite. Evidence of timely submissions, and a template for notification communication to member/provider was not submitted for review. Post-onsite, the MCO revised the policy A-LA 7200.05 Concurrent Review: Inpatient, pgs. 9-10 to include required language. File Review Results: None (0) of the ten (10) UM denial files reviewed onsite involved an inpatient psychiatric hospitalization concurrent UR; results are NA for this element. Recommendation: The MCO updated the policy A-LA 7200.05 Concurrent Review: Inpatient, pgs. 9-10 to include required language; evidence of timely submissions, and a template for notification communication to member/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
	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, 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,	Desktop: Prior Authorization and Concurrent Review for Psychiatric Residential Treatment Facilities (PRTF) Introduction p 1 Post-onsite:	Full	Prior to the onsite, the unsigned submitted document contained contract language except for, "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-	

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 addition to the recommendations of a team specified at 42 CFR §441.154.	Prior Authorization for Psychiatric Residential Treatment Facilities Desktop, pg. 1		face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154." Post-onsite all required language was found in the submitted Prior Authorization for Psychiatric Residential Treatment Facilities Desktop which has an effective date within the RP (12/1/2015), meeting the requirement.	
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).	Desktop: Prior Authorization and Concurrent Review for Psychiatric Residential Treatment Facilities (PRTF) Certification and Recertification of PRTF Services pp 1 – 2 Post-onsite: Prior Authorization for Psychiatric Residential Treatment Facilities Desktop, pg. 1	Full	Prior to the onsite, the contract language was not found in the document, Desktop: Prior Authorization and Concurrent Review for Psychiatric Residential Treatment Facilities (PRTF) which was unsigned and undated. The MCO stated onsite that an LMHP subcontract was not submitted for review because they only use an internal team. Post-onsite required language was found in the submitted Prior Authorization for Psychiatric Residential Treatment Facilities Desktop which has an effective date within the RP (12/1/2015), meeting the requirement.	
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.	Desktop: Prior Authorization and Concurrent Review for Psychiatric Residential Treatment Facilities (PRTF), pg. 1 Post-onsite: Prior Authorization for Psychiatric Residential Treatment Facilities Desktop, pg. 2	Full	Post-onsite required language was found in the submitted Prior Authorization for Psychiatric Residential Treatment Facilities Desktop, pg. 2 which has an effective date within the RP (12/1/2015), meeting the requirement.	
8.4.4.4.5	In addition to certifying the need, the MCO shall:	Desktop: Prior Authorization and Concurrent Review for	Full	Post-onsite, required language was found in the submitted Prior	

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
	• 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 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.	Psychiatric Residential Treatment Facilities (PRTF), pg. 1 Post-onsite: Prior Authorization for Psychiatric Residential Treatment Facilities Desktop, pgs. 1-3 329 ABH 2016 Q2 Resubmit2 329 ABH 2016 Q3		Authorization for Psychiatric Residential Treatment Facilities Desktop, pgs. 1-3 which has an effective date within the RP (12/1/2015), and tracking reports 329 provide evidence of implementation to meet this requirement.	
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	N/A	The MCO did not submit documents for review and stated onsite that TFC is not currently in their contract as it is a waiver service that might be in place for some DCFS-preferred plans.	
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	A-LA 7100.05 Prior	Full	The requirement is met in the 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**
	standard service authorization 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.	Authorization Definitions pp 2-6 Decision/Notification Requirements Grid – pp 14 - 15		A-LA 7100.05 Prior Authorization Definitions pgs. 2-6, Decision/Notification Requirements Grid – pgs. 14 – 15. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness.	
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.	A-LA 7200.05 Concurrent Review: Inpatient, pg. 3 and pg. 12 A-LA 7100.05 Prior Authorization, pg.4 and pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 21	Substantial	Prior to the onsite, the element percentages were not found in the submitted policies. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, p. 6, pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 19	Substantial	The requirement language was not found in one statement but in different areas of the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 19 to include required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for	

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
				notification of the circumstances under which expedited resolution is available and how to request it; six (6) of the ten (10) files were not compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 19 to include required language, and to meet compliance. The MCO should include the circumstances under which expedited resolution is available and how to request it in notification letters.	
8.5.2.2	The MCO may extend the seventy-two (72) 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.	A-LA 7100.05 Prior Authorization, p. 6, pg. 14 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 22	Substantial	Prior to the onsite, the submitted policy excluded "justifies to DHH" language. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 22 to include required language. File Review Results: None (0) of the ten (10) UM denial/adverse action files reviewed onsite involved an extension; results are NA for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 22 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, pgs. 14-15, p. 19 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 25	Substantial	The following language was not found in the submitted policy prior to the onsite, "but in no instance later than one hundred, eighty (180) days from the date of service." Post-onsite, the MCO revised A-LA	

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
				7100.05 Prior Authorization (2), pg. 25 to include required language. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language, and to meet compliance.	
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.	A-LA 7150.05 Medical Claims Review, pg 2 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 25	Substantial	Prior to the onsite, the required language was not found in the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 25 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization, pgs. 13-15. Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 18	Substantial	Prior to the onsite, the element language was not clearly stated as presented in the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 18 to include required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 18 to include required language, and to meet compliance.	
8.5.4.1.1.2	For service authorization approval for	A-LA 7100.05 Prior	Substantial	Prior to the onsite, the contract	

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
	extended stay or additional services, the MCO 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.	Authorization15 – 16 Post-onsite: A-LA 7100.05 Prior Authorization (2), pgs. 18-19		language was not found in the submitted policy. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pgs. 18-19 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pgs. 18-19 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization Definitions pp 2-6 Notice of Action Requirements pp 19-20	Full	This requirement is met in the P/P A-LA 7100.05 Prior Authorization Definitions pgs. 2-6, Notice of Action Requirements pgs. 19-20. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for providing the reason for the action (denial) being taken 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. Four (4) of the ten (10) 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 four (4) of the four (4) 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	A-LA 7100.05 Prior Authorization Decision/Notification Requirements p 14 – 15 Notice of Action Requirements pp 19-20	Substantial	Prior to the onsite, the submitted policy stated that the non-urgent pre-service denial notification method is Electronic/Written vs. verbal/oral on pg. 14 of Policy. Post-onsite, the MCO updated A-LA	

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
	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.	Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 21		7100.05 Prior Authorization (2), pg. 21 to include required language. File Review Results: All ten (10) of the ten (10) UM denial/adverse action files reviewed onsite were compliant for timeliness. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 21 to include required language, and to meet compliance.	
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.	2016 UM Program Description Peer to Peer Consultation PP 22-23 A-LA 7100.05 Prior Authorization P 5 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.13	Substantial	Prior to the onsite, the 2016 UM Program Description, was not a dated policy in RP; it only addressed Peer to Peer vs., member's rights. The policy A-LA 7100.05 Prior Authorization, pg. 5 referenced "Peer to Peer," but not a member's rights. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 13 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 13 to include required language, and to meet compliance.	
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	2016 UM Program Description P 23 Post-onsite:	Substantial	Prior to the onsite, the 2016 UM Program Description, was not a dated policy in RP; it only addressed Peer to Peer vs., member's rights.	

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
	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)].	A-LA 7100.05 Prior Authorization (2), pg.13		Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 13 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for this element. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 13 to include required language, and to meet compliance.	
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.	2016 UM Program Description P 23	Full	The requirement is met in the 2016 UM Program Description, pg. 23. File Review Results: Five (5) of five informal reconsideration files were compliant.	
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.	A-LA 3100.70 Member Appeals Definitions p.2 Scope p.8 Post-onsite: A-LA 3100.70 Member Appeals, pg. 9	Substantial	The submitted policy prior to the onsite had 30-day timeframe but not: "The Informal Reconsideration will in no way extend" element language. Post-onsite, the MCO updated the policy A-LA 3100.70 Member Appeals, pg. 9 to include the required language. File Review Results: Four (4) of the ten (10) UM denial/adverse action files reviewed onsite involved reconsiderations and all four (4) of the four (4) files were compliant for timeliness.	

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 MCO revised the policy A-LA 3100.70 Member Appeals, pg. 9 to include required language, and to meet compliance.	
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	A-LA 7100.05 Prior Authorization, pgs. 7-8 2016 UM Program Description, pg. 21 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.	Full	This requirement is met in the P/P A-LA 7100.05 Prior Authorization, pgs. 7-8, and in the 2016 UM Program Description, pg. 21.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	A-LA 7100.05 Prior Authorization, pg.9 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 9	Substantial	The required contract language was not found in the submitted policy prior to the onsite. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	A-LA 7100.05 Prior Authorization, pg. 2 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.9	Substantial	Prior to the onsite, the policy did not state, “authorization or referrals”; states except EPSDT. Post-onsite, the MCO revised A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
8.5.4.2	The MCO shall not require service authorization for the continuation of	A-LA 7000.40 Member Transition, pg. 4-6	Substantial	Prior to the onsite, the contract language was not found in the	

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
	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.	Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 9		submitted policy A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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.	A-LA 7000.40 Member Transition, pg. 6 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 9	Substantial	Prior to the onsite, the contract language was not found in the submitted policy A-LA 7000.40 Member Transition. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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 preventive women's healthcare services and prenatal care.	A-LA 7100.10 Elective Referrals, pg. 4	Full	The requirement is met in the P/P A-LA 7100.10 Elective Referrals, pg. 4.	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	A-LA 7100.10 Elective Referrals, pg. 8 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg.	Substantial	Prior to the onsite, the policy A-LA 7100.10 Elective Referrals, pg. 8, states "for members under age 21." Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include the required language. Recommendation:	

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
				The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 9 to include required language, and to meet compliance.	
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.	A-LA 7000.42 Prenatal Services, pg. 7 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	Prior to the onsite, the contract language not found in the policy A-LA 7000.42 Prenatal Services, pg. 7. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
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.	Desktop: Obstetrical Admit for Deliveries, pg. 1 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	Prior to the onsite, the contract language was not found in the submitted document Desktop: Obstetrical Admit for Deliveries, pg. 1 which is not a signed policy. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	A-LA 7200.05 Concurrent Review: Inpatient/Observation Setting, pg. 9 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 10	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7200.05 Concurrent Review: Inpatient/Observation Setting, pg. 9. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 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 MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 10 to include required language, and to meet compliance.	
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.	A-LA 7100.05 Prior Authorization PP 9-11 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 15	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 7100.05 Prior Authorization. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 15 to include the required language. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 15 to include required language, and to meet compliance.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	A-LA 7100.05 Prior Authorization Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Members pp 14-20 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14 ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016	Substantial	Prior to the onsite, the contract language was not found in the submitted policy or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language, and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template 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
				contract to meet compliance.	
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.	2016 UM Program Description Process for Making Determinations of Medical Necessity and Benefits Coverage pp 18-23 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14 ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016	Substantial	Prior to the onsite, the contract language was not found in the UM PD or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. Recommendation: The MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template provider contract to meet compliance.	
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.	A-LA 3000.18 Enforcement Mechanisms Focus/Disposition pp 2-4 Post-onsite: A-LA 7100.05 Prior Authorization (2), pg. 14	Substantial	Prior to the onsite, the contract language was not found in the policy A-LA 3000.18 Enforcement Mechanisms Focus/Disposition, or in the Provider Handbook, and provider contracts were not submitted for review for this element. Post-onsite, the MCO revised the policy A-LA 7100.05 Prior Authorization (2), pg. 14 to include the required language, and provided the template provider contract ABH LA Medicaid Compliance Addendum Provider - Exhibit A - V.5.12.2016 to meet this requirement. Recommendation: The MCO revised the policy A-LA	

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
				7100.05 Prior Authorization (2), pg. 14 to include required language, and submitted a template provider contract to meet compliance.	
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.	A-LA 8000.34 Practitioner and Provider Performance Data Focus/Disposition, pp. 1-2 2016 UM Program Description Utilization Management Monitoring and Reporting pp 25-37	Substantial	The MCO stated onsite that they do not have BH profiling for 2015 as it was integrated in December 2015; signed BH attestations for January, April, July and October2016 were submitted for review. Prior to the onsite, the contract language is addressed in 2016 UM Program Description Utilization Management Monitoring and Reporting pg. 29, without a specific reference to BH providers. Post-onsite, the MCO revised the policy A-LA 8000.34, pg. 2 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pg. 2 to include the required language, and to meet compliance.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	2016 UM Program Description PP 27-28	Full	Prior to the onsite, the contract language was found in the 2016 UM Program Description pgs. 27-28, signed in the RP (8-18-16).	
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:	2016 UM Program Description P 28 Utilization/Performance Improvement Indicators pp 27-28 Behavioral Health Services P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data,	Substantial	Evidence of timely submission of profiling report was submitted prior to the onsite, but the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation:	

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
		pp. 2-3		The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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;	2016 UM Program Description P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data, pp. 2-3	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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;	2016 UM Program Description P 31 Post-onsite: A-LA 8000.34 Practitioner and Provider Performance Data, pp. 2-3	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
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;	2016 UM Program Description, pg. 31	Substantial	Prior to the onsite, the contract language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
8.12.3.4	Hospital admits, lab services, medications,	2016 UM Program Description	Substantial	Prior to the onsite, the contract	

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**
	and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	P 27, 29 pp 25-37		language was not found in the UM PD. Post-onsite, the MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language. Recommendation: The MCO revised the policy A-LA 8000.34, pgs. 2-3 to include the required language, and to meet compliance.	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	2016 UM Program Description P 29 Utilization Management Monitoring and Reporting pp 25-37	Substantial	Element language for individual provider performance measures is addressed in the 2016 UM Program Description Utilization Management Monitoring and Reporting pgs. 25-37. It is unclear whether Appendix J has been retired and whether Appendix J measure results are required for compliance. Recommendation: The MCO should clarify this requirement with LDH.	
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.	-LA 8000.30 Review of Practitioner Office Medical Records P 4 Method of Case Selection pp 4 - 8 PQ069 Utilization Management Summary Report 2016 069 Report Submissions 069 ABH 2015 Q4 Exhibit 1 069 ABH 2015 Q4 AT Exhibit 2	Full	This requirement is met in the policy LA 8000.30 Review of Practitioner Office Medical Records, with evidence of implementation provided in the PQ069 Utilization Management Summary Report and 069 Report Submissions attestations of timely submission.	

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
		069 ABH 2016 Q1 Exhibit 1 069 ABH 2016 Q1 AT Exhibit 2 069 ABH 2016 Q2 Exhibit 1 069 ABH 2016 Q2 AT Exhibit 2 069 ABH 2016 Q3 Exhibit 1 069 ABH 2016 Q3 AT Exhibit 2			

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.	4500.01 Member Disenrollment Policy-Member Initiated Disenrollment, page 3.	Full	The requirement is stated verbatim on page 3 of 4500.01.	
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 services area, i.e. out of state; or • Any other reason deemed to be valid by	4500.01 Member Disenrollment Policy-Member Initiated Disenrollment, page 3.	Full	All components of this requirement are stated verbatim, except for "The member's active behavioral health provider ceases to contract with the MCO." However, this component would fall under the category of "Any other reason deemed to be valid by LDH and/or its agent."	

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 reason: • 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).	4500.01 Member Disenrollment Policy-Member Initiated Disenrollment, pages 3-4.	Full	The requirement is stated verbatim on pages 3-4 of 4500.01.	
11.11.3.3	The member (or his/her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	4500.01 Member Disenrollment Policy-Member Initiated Disenrollment, page 3.	Full	The requirement is stated verbatim on page 3 of 4500.01.	
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.	4500.01 Member Disenrollment Policy-Member Initiated Disenrollment, page 4.	Full	The requirement is stated verbatim on page 4 of 4500.01.	
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 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)).	4500.01 Member Disenrollment Policy-Aetna Better Health Initiated Disenrollment, page 4.	Full	The requirement is stated verbatim on page 4 of 4500.01.	
11.11.4.2	The MCO shall not request disenrollment for	4500.01 Member	Full	The requirement is stated verbatim	

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
	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.	Disenrollment Policy-Aetna Better Health Initiated Disenrollment, page 4.		on page 4 of 4500.01.	
11.11.4.3	The following is the only allowable reason for which the MCO may request involuntary disenrollment of a member: if 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;	4500.01 Member Disenrollment Policy-Aetna Better Health Initiated Disenrollment, page 4.	Full	The requirement is stated verbatim on page 4 of 4500.01.	
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.	4500.01 Member Disenrollment Policy-Aetna Better Health Initiated Disenrollment, page 5.	Substantial	On page 5 of 4500.01, the requirement is addressed. However, in regard to the effective date, the policy only states "The notice includes… an explanation that Aetna Better Health is requesting that the member be disenrolled in the month following member notification." During the onsite interview, the MCO clarified that the effective date would be no earlier that the first of the month following the date of the notification to the member. The MCO has also updated the language within the policy to state the requirement verbatim following the onsite visit. The correction was made after the review period but no further action is necessary	
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	4500.01 Member Disenrollment Policy-Submitting Involuntary Disenrollment Requests, page 5.	Full	The requirement is stated verbatim on page 5 of 4500.01.	

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**
	MCO Initiated Request for Member 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.	4500.01 Member Disenrollment Policy-Submitting Involuntary Disenrollment Requests, page 5.	Full	The requirement is stated verbatim on page 5 of 4500.01.	
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.	4500.01 Member Disenrollment Policy-Involuntary Disenrollment Approval Process, page 5.	Full	The requirement is stated verbatim on page 5 of 4500.01.	
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.	4500.01 Member Disenrollment Policy-Disenrollment Effective Date, page 6.	Full	The requirement is stated verbatim on page 6 of 4500.01.	

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.	A-LA 4500.20 Member Materials Standards Material Standards Section 2016 Annual Notification to Members	Full	The requirement is addressed in A-LA 4500.20 Member Materials Standards, page 2. However, it is missing language regarding explanation of technical terms. During the onsite, the MCO commented that to determine reading level for the member handbook and website, the content is run through a system that breaks it down to the appropriate grade level. However, this process is conducted at the corporate, not individual MCO level. Recommendation: Develop or revise local MCO-level policies to explain the process for accommodating reading level.	
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.	Member Handbook A-LA 4500.20 Member Materials Standards Alternative Formats Section	Full	The requirement is addressed in A-LA 4500.20 Member Materials Standards, page 2. However, it does not specify font size or exceptions. During the onsite, the MCO commented that to determine reading level for the member handbook and website, the content is run through a system that breaks it down to the appropriate grade level. However, this process is conducted at the corporate, not individual MCO level. Recommendation: Develop or revise local MCO-level policies to explain the process for determining legibility and font size.	

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
12.9.3	DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.	A-LA 4500.20 Member Materials Standards Required Approvals Section	Full	The requirement is addressed in A-LA 4500.20 Member Materials Standards, page 3.	
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.	A-LA 4600.05 Member Communications Purpose Section	Full	MCO Onsite Comment: Before a testimonial or picture is distributed to the public, Aetna will request a disclosure be completed. The MCO will provide a blank copy of the disclosure form. This occurs at community events as well. Offsite, a copy of the Photo and testimonial release form was reviewed.	
12.9.5	All written materials must be in accordance with the DHH "Person First" Policy, Appendix NN.	Member Handbook 2016 Annual Notification to Members A-LA 4500.35 Member Rights and Responsibilities Members Have the Following Rights Section	Full	MCO Onsite Comment: Members' rights and responsibilities and member handbook address this requirement.	
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.	Member Handbook 2016 Annual Notification to Members	Full	MCO Onsite Comment: Aetna corporate handles printing. To the MCO's knowledge materials are the same as Medicaid. Recommendation: Develop or revise local MCO-level policies regarding the quality of the materials.	
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-d marketing materials.	2016 Annual Notification to Members	Full	The requirement is addressed on EPSDT-LA.	
12.9.8	All multi- 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;	A-LA 4500.35 Member Rights and Responsibilities Member Have the Following Rights Section A-LA 4500.26 Translation Services Interpreter Services Section	Full	The requirement is addressed in the Member Handbook, page 16.	
12.9.9	All written materials related to MCO and PCP	Member Handbook	Full	MCO Onsite Comment: Customer	

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**
	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.	2016 Annual Notification to Members		Representative will inform callers to check with potential enrollees and with participating providers and to review the website for participating providers. This happens frequently during open enrollment. The MCO does not market to potential enrollees.	
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.	A-LA 4500.20 Member Materials Standards Alternative Formats Section	Full	The requirement is addressed in Member Handbook, pages 2 and 12.	
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.	A-LA 4500.35 Member Rights and Responsibilities Members Have the Following Rights Section A-LA 4500.01 Member Disenrollment Purpose Section A-LA 4500.01 Member Disenrollment Member Initiated Disenrollment Section	Full	This requirement is addressed in A-LA 4500.01 Member Disenrollment Policy.pdf, page 1.	
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;	https://medicaid.aetna.com/MWP/login.fcc?TYPE=33554433&REALMOID=06-8b99ae55-7f0b-42c8-bb2c-ad6a6000c7ee&GUID=&SMAUTHREASON=0&METHOD=GET&SMAGENTNAME=yDnERTCDNc4ySe3gOph3XXzZ5ivKCiuMbjfUdnIRCYo4y6nCZ0RPZYUcXr96NUSO&TARGET=-SM-https%3a%2f%2fmedicaid%2eaetna%2ecom%2fMWP%2flanding%2flogin	Full	Onsite walkthrough of member portal and website was conducted and the requirement was addressed.	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to	LA-Fa16- 508- eng LA-FaWi16-508-eng LA- Su16-508-eng	Full	The requirement is addressed in LA-Fa16-508-eng; LA-FaWi16-508-eng; and LA- Su16-508-eng.	

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
	PCPs and other providers and other information that is helpful to members;				
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;	Growth Chart EPSDT Material Value ADDS Member added Benefits	Full	The requirement is addressed in Growth Char.pdf; EPSDT-LA.pdf; and Value Adds member added benefits in detail V3 (FINAL).pdf.	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Diabetes-eng-LA Depression-eng-LA Heart-eng-LA HIV-eng-LA Sickle Cell-eng-LA	Full	The requirement is addressed in diabetes-eng-LA.pdf; depression-eng-LA.pdf; heart-eng-LA.pdf; and HIV-eng-LA.pdf.	
12.11.3.5	Materials focused on health promotion programs available to the members;	LA-Swim-Lessons-Flyer-Update	Full	The requirement is addressed in LA-Swim-Lessons-Flyer-Update.pdf.	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member Handbook -Self-Referral/Healthy Tips 2016 Annual Notification Member	Full	The requirement is addressed in 2016 Annual Notification Member.pdf.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member Handbook -Nurses, behavioral health professionals, and community health workers LA-Swim-Lessons-Flyer-Update	Full	The requirement is addressed in the Member Handbook, pages 24-27; and in LA-Swim-Lessons-Flyer-Update.pdf.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Diabetes-eng-LA Depression-eng-LA Heart-eng-LA HIV-eng-LA Sickle Cell-eng-LA	Full	The requirement is addressed in diabetes-eng-LA.pdf; depression-eng-LA.pdf; heart-eng-LA.pdf; and HIV-eng-LA.pdf.	
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;	Growth Chart Diabetes-eng-LA Depression-eng-LA Heart-eng-LA HIV-eng-LA Sickle Cell-eng-LA	Full	The requirement is addressed in diabetes-eng-LA.pdf; depression-eng-LA.pdf; heart-eng-LA.pdf; and HIV-eng-LA.pdf.	
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	A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Network Changes Section	Full	During the onsite, the MCO stated that LDH would notify members and then cc the MCO. As of yet, the MCO has not issued such notice of	

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**
				change.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	A-LA 4600.05 Member Communications Aetna Medicaid Marketing Approval Process Section	Full	The requirement is addressed in A-LA 4600.05, page 3.	
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.)..	Member Handbook Member Handbook BH	Full	The handbook was updated to integrate BH requirements.	
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;	Table Of Contents	Full	The requirement is addressed in Member Handbook, page 5.	
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;	Member Handbook- Eligibility and enrollment Member Handbook- Your rights and responsibilities Member Handbook -Your rights (Appropriate Utilization) Member Handbook -Your primary care provider (PCP)	Full	The requirement is addressed in Member Handbook, pages 12, and 15-18.	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook - Disenrollment	Full	The requirement is addressed in Member Handbook, pages 48-49.	
12.12.1.5	Member's right to change providers within the MCO;	Member Handbook -How do I change my PCP?	Full	The requirement is addressed in Member Handbook, pages 17-18.	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook -Types of primary care providers	Full	This requirement is addressed in Member Handbook, page 17.	
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook -Your rights and responsibilities	Full	The requirement is addressed in Member Handbook, pages 15-17.	
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	Member Handbook -Covered Services and Extra Benefits For Our Members	Full	The requirement is addressed in Member Handbook, pages 19-27.	

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
	promotion programs, including chronic care management, tobacco cessation, and problem gaming;				
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook -Getting prior authorization for services	Full	The requirement is addressed in Member Handbook, pages 18 and 27-28.	
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;	Member Handbook - Identification card	Full	The requirement is addressed in Member Handbook, pages 18 and 15.	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;	Member Handbook -Family Planning Services	Full	The requirement is addressed in Member Handbook, pages 18 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.	Member Handbook - Emergency Care Member Handbook -Getting Prior Authorization for Services Member Handbook - Emergency Care Member Handbook -Types of Care (Emergency) Member Handbook -Types of Care (Emergency)	Full	The requirement is addressed in Member Handbook, pages 38 and 40.	
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook- Type of Care (What are post-stabilization services?)	Full	The requirement is addressed in Member Handbook, pages 18 and 41.	
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;	Member Handbook -Self-Referrals	Full	The requirement is addressed in Member Handbook, pages 18 and 42.	
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	Member Handbook -Medicaid Covered Services	Full	The requirement is addressed in Member Handbook, pages 18 and 27.	

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
	MCO's contract with DHH;				
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;	Member Handbook -Your rights and responsibilities (Your rights)	Full	The requirement is addressed in Member Handbook, pages 18 and 15.	
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;	Member Handbook - Disenrollment (Disenrollment from Aetna Better Health of Louisiana)	Full	The requirement is addressed in Member Handbook, pages 18 and 49.	
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;	Member Handbook - Grievance and Appeals	Full	The requirement is addressed in Member Handbook, pages 44-48.	
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 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.	Member Handbook - Grievance and Appeals (State Fair Hearing) Member Handbook - Grievance and Appeals (What is a Grievance) Member Handbook - Grievance and Appeals (The Grievance Process) Member Handbook - Grievance and Appeals	Full	The requirement is addressed in Member Handbook, pages 45-47	
12.12.1.20	Advance Directives, set forth in 42 CFR	Member Handbook Advance	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
	§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 given.	directives Member Handbook Advance directives (Mental Health Advance Directives) Member Handbook Advance directives (Mental Health Advance Directives)		Member Handbook, pages 49-50.	
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;	Member Handbook- Your information	Full	The requirement is addressed in Member Handbook, pages 12, 16 and 44.	
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";	Member Handbook- Getting care (Quick tips about appointments)	Full	The requirement is addressed in Member Handbook, pages 18.	
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;	Member Handbook- Your member handbook (Member Services)	Full	The requirement is addressed in Member Handbook, pages 11. Link to email is available on website. URL is available in Member Handbook.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook- Transportation	Full	The requirement is addressed in Member Handbook, pages 4, 19 and 38.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Member Handbook- Well baby and well child	Full	The requirement is addressed in Member Handbook, pages 19, 21	

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
	services;			and 35.	
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;	Member Handbook- Other Insurance	Full	The requirement is addressed in Member Handbook, pages 18 and 44.	
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;	Member Handbook- Other Insurance	Full	The requirement is addressed in Member Handbook, pages 18 and 41.	
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;	Member Handbook- Your responsibilities	Full	The requirement is addressed in Member Handbook, pages 15-16.	
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 ;	Member Handbook- Your member handbook (Language services)	Substantial	The requirement is partially addressed in Member Handbook, inside cover page, and pages 4, 12 and 16. The Member Handbook does not include a statement on how to obtain materials or translation services in Spanish. Onsite an approved draft of other member marketing materials was reviewed that has notification that a Spanish version is available. Recommendation: Update member handbook to include statements in both English and Spanish about the availability of materials in alternative languages.	
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;	Member Handbook- Getting a second opinion	Full	The requirement is addressed in Member Handbook, page 18.	

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
12.12.1.31	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;	Member Handbook- Fraud and Abuse	Full	The requirement is addressed in Member Handbook, inside cover page, pages 3 and 48.	
12.12.1.32	Any additional text provided to the MCO by DHH or deemed essential by the MCO;	Member Handbook- Resources	Full	The requirement is addressed in Member Handbook, page 11.	
12.12.1.33	The date of the last revision;	Member Handbook- 12/7/15	Full	The requirement is addressed in Member Handbook, cover page.	
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.	Member Handbook- Quality improvement programs Member Handbook- Physician incentive plan Member Handbook- Losing your benefits and services Member Handbook- Report Marketing Violations	Full	The requirement is addressed in Member Handbook, paged 43-44 and 48.	
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.	Member Handbook- Behavioral Health Services Member Handbook- Behavioral Health/ Provider Directory Member Handbook- What are “best practices” in behavioral health, and how do best practices affect the services I receive? Member Handbook- What happens after I am enrolled with Aetna Better Health of Louisiana for behavioral health? Member Handbook- Confidentiality of substance use treatment services	Full	The requirement is addressed in Member Handbook, pages 27, 29-32 and 55.	
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	2016 Annual Notification Member	Full	The requirement is addressed in 2016 Annual Notification Member, page 1.	

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
	hardcopy, upon request from the member.				
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.	12/7/15	Full	The requirement is addressed in A-LA 4600.05 Member Communications, page 3. MCO Onsite: Publication date of the last member handbook is 12/7/15. The Handbook is submitted to LDH for approval.	
12.14	**Provider Directory for Members**				
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	A-LA 6300.20. Provider Directory Updates. Purpose Section A-LA 6300.25 Provider Directory Responsibilities Section	Full	The requirement is addressed in A-LA 6300.25 Provider.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	A-LA 6300.20. Provider Directory Updates. Updating and validation of the Provider Directory Access Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, pages 2-3.	
12.14.1.2	Web-based, searchable, online directory for members and the public;	A-LA 6300.20 Provider Directory Updates. Updating and Validation of the Provider Directory A-LA 6300.25 Provider Directory Responsibilities Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, pages 2-3.	
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	A-LA 6300.20. Provider Directory Updates. Updating and validation of the Provider Directory Access Section A-LA 6300.25 Provider Directory Responsibilities Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, pages 2-3. During the onsite, the MCO stated that submissions are made weekly.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	A-LA 6300.25 Provider Directory Responsibilities Section A-LA 6300.25 Provider Directory Responsibilities Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, pages 2-3.	
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	A-LA 6300.20 Provider Directory Updates. Updating and validation of the Provider Directory Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, page 7.	

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
	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 DHH.	A-LA 6300.25 Provider Directory Update and Validation of provider directory Section			
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;	A-LA 6300.20 Provider Directory Updates A-LA 6300.25 Provider Directory Provider Web-Based Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, pages 3-4.	
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;	A-LA 6300.20 Provider Directory Updates. Focus/Disposition Section A-LA 6300.25 Provider Directory Provider Web-Based Section	Full	The requirement is addressed in ProviderDirectory-LA.pdf. Patient age limitations are noted for each provider and provider site. Providers are delineated by Parish; and zip codes are presented.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	A-LA 6300.20 Provider Directory Updates. Assessment of Physician Directory Accuracy Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, page 4.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5	A-LA 6300.25 Provider Directory Paper Directory Section	Full	The requirement is addressed in A-LA 6300.25 Provider Directory, page 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
	p.m. or any weekend hours).	Provider Directory			
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.	Member Handbook- Your rights and responsibilities A-LA 4500.35 Members Rights and Responsibilities Provider Manual Member Responsibilities Section	Full	The requirement is addressed in A-LA 4500.35 Members Rights and Responsibilities.	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Member Handbook- Your rights and responsibilities(Your Rights) A-LA 4500.35 Members Rights and Responsibilities Provider Manual Member Responsibilities Section	Full	The requirement is addressed in A-LA 4500.35 Members Rights and Responsibilities, pages 2-5; and Member Handbook, pages 15-16.	
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.	Member Handbook- Your rights and responsibilities (Your Responsibilities) ABH LA Provider Phys Group Template A-LA 4500.35 Members Rights and Responsibilities Members Have the Following Rights Section Provider Manual Member Responsibilities Section	Full	The requirement is addressed in Member Handbook, pages 15-17.	
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;	Member Handbook- Your rights and responsibilities(Your responsibilities) A-LA 4500.35 Members Rights and Responsibilities Member Responsibilities Section	Full	The requirement is addressed in Member Handbook, pages 15-17.	

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**
	• 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 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.	A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Department Provider Terminations Section	Full	The requirement is addressed in A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations, page 4.	
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	A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Department Provider Terminations Section A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations Member Continuity of Care Section	Not Met	The A-LA 6100.90 Provider Network Voluntary and Involuntary Terminations policy states on page 3 that the LDH will be notified within seven (7) business days, rather than seven (7) calendar days as noted in the requirement. The policy states on page 4 that members will be notified within fifteen (15) calendar days, rather than the seven (7) calendar days noted in the requirement. Recommendation: Revise policy to reflect correct	

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
	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.			timeframes noted in requirement.	
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 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.	A-LA 4500.26 Translation Services Interpreter Services Section	Full	The requirement is addressed in A-LA 4500.26 Translation Services, page 2.	
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).	A-LA 4500.26 Translation Services Interpreter Services Section	Substantial	The requirement is partially addressed in A-LA 4500.26 Translation Services, page 2. The MCO policy states 5% or more, in conflict with the contract language which states 4% or more. During the onsite, the MCO stated that the plan does not have a primary language that is spoken by more than 4% of their membership. In addition, the MCO produces all written materials in Spanish. Recommendation: The MCO should revise the policy to reflect 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
13.0	**Member Grievance and Appeals Procedures**				
13.2					
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.	A-LA 3100.70 Member Appeals Request for State Fair Hearing Sections pg 4 A-LA 3100.90 Member Grievances A-LA 7100.05 Prior Authorization	Full	The requirement is met in the P/Ps A-LA 3100.70 Member Appeals Request for State Fair Hearing, A-LA 3100.90 Member Grievances, and A-LA 7100.05 Prior Authorization with evidence of implementation in file review results and template letters as noted in elements below.	
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.	A-LA 3100.70 Member Appeals pg 4 A-LA 3100.90 Member Grievances pg. 4	Full	The requirement is met in A-LA 3100.70 Member Appeals pg 4and A-LA 3100.90 Member Grievances pg. 4.	
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.	A-LA 3100.70 Member Appeals pg. 4 A-LA 3100.90 Member Grievances pg. 4	Full	The requirement is met in A-LA 3100.70 Member Appeals pg. 4 and A-LA 3100.90 Member Grievances pg. 4.	
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.	A-LA 3100.70 Member Appeals pgs. 4-6	Full	The requirement is met in A-LA 3100.70 Member Appeals pgs. 4-6.	
13.2.4 13.2.4.1	**Procedures for Filing** The member or provider may file an appeal either orally or in writing.	A-LA 3100.70 Member Appeals pgs. 4, 7	Full	The requirement is met in A-LA 3100.70 Member Appeals pgs. 4, 7.	
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	A-LA 3100.90 Member Grievances A-LA 3100.70 Member Appeals, pg. 4-5	Full	The requirement is met in A-LA 3100.90 Member Grievances pg. 5, in A-LA 3100.70 Member Appeals, pg. 4-5, in the Member Handbook, and on the MCO website.	

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
	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.				
13.3	**Grievance/Appeal Records and Report**				
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.	A-LA 3100.90 Member Grievances, pg. 8 A-LA 3100.70 Member Appeals, pg. 10	Full	The requirement is met in A-LA 3100.90 Member Grievances, pg. 8 and A-LA 3100.70 Member Appeals, pg. 10.	
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.	Pre-onsite: A-LA 3100.73 Reporting Appeal State Report Template Grievance State Report Template A-LA 3100.90 Member Grievances, pg. 9 A-LA 3100.70 Member Appeals, pg. 18 Post-onsite: ABH 2016 112 and 113 reports	Full	The requirement is met in: A-LA 3100.73 Reporting, Appeal State Report Template, Grievance State Report Template, A-LA 3100.90 Member Grievances, pg. 9, and A-LA 3100.70 Member Appeals, pg. 18. Evidence of monthly submissions meeting format requirements was provided in the monthly ABH 2016 112 and 113 reports submitted for review after the onsite.	
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.	A-LA 3100.70 Member Appeals. Pg. 13	Full	The requirement is met in A-LA 3100.70 Member Appeals. Pg. 13.	
13.4	**Handling of Grievances and Appeals**				
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:				

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
13.4.1.1	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;	A-LA 3100.70 Member Appeals, pg. 7 A-LA 3100.90 Member Grievances, pg. 8-9 Appeal Acknowledgment Template Grievance Acknowledgment Template	Full	The requirement is met in: A-LA 3100.70 Member Appeals, pg. 7 A-LA 3100.90 Member Grievances, pg. 8-9, Appeal Acknowledgment Template, and in Grievance Acknowledgment Template.	
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;	A-LA 3100.70 Member Appeals, pg. 7 A-LA 3100.90 Member Grievances, pg 4	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 7, A-LA 3100.90 Member Grievances, pg 4, and in the Member Handbook.	
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 clinical issues.	A-LA 3100.70 Member Appeals, pgs.7-8 A-LA 3100.90 Member Grievances, pg. 4	Full	The requirement is met in A-LA 3100.70 Member Appeals, pgs.7-8 and A-LA 3100.90 Member Grievances, pg. 4. File Review Results: Fourteen (14) of the fifteen (15) grievance files reviewed onsite involved a previous level of decision making, and all fourteen (14) of the fourteen (14) files were compliant for this element.	
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.	A-LA 3100.70 Member Appeals, pg. 7 Appeal Acknowledgment Letter Template Member Handbook, pg. 45	Substantial	The P/P A-LA 3100.70 Member Appeals, pg. 7 has the contract language but the contract language was not found in the Member Handbook, pg. 45, or in the letter template. Recommendation: The contract language should be added to the Member Handbook and to the confirmation letter template.	
13.4.2.2	Provide the member a reasonable	A-LA 3100.70 Member	Full	The requirement is met in A-LA	

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
	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).	Appeals pg. 8 Member Handbook, pg 46		3100.70 Member Appeals pg. 8, and the Member Handbook, pg 48. File Review Results: Of the ten (10) appeals files reviewed, none had evidence of this language in the appeal acknowledgement letter. However, this language is available in the original denial letter: "You can provide additional information to assist us in making the decision." "If your condition is considered urgent, we may be able to make a decision about your appear much sooner." Recommendation: Add requirement to the appeal acknowledgement letter.	
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.	A-LA 3100.70 Member Appeals pg. 8 Member Handbook pg.46	Substantial	The P/P A-LA 3100.70 Member Appeals pg. 8 contains contract language. The contract language is not found in Member Handbook pg.46. File Review Results: Ten (10) of ten (10) appeal files reviewed included appeal acknowledgement letters that included in the following language: "You or your representative may see any information we reviewed about your appeal." Recommendation: The MCO should add the required language to the Member Handbook.	
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.	A-LA 3100.70 Member Appeals pg. 8 Member Handbook pg. 45	Substantial	The P/P A-LA 3100.70 Member Appeals pg. 8 contains contract language. Contract language is not found in Member Handbook pg.45. File Review Results:	

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
				Ten (10) of ten (10) appeal files reviewed demonstrated evidence of the requirement. Recommendation: The MCO should add the required language 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.	Learning Transcript	Substantial	Training Agendas and attachments and Sign-in sheets were not submitted for review. The submitted learning transcript does not indicate that training was for the LA Plan or was for grievance and appeal training. In response the MCO stated that it's an electronic sign in for all phone staff with mandatory compliance every two months. A report or some evidence of training taking place was requested onsite. Recommendation: The MCO should provide a training report or some evidence in support of this requirement.	
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.	Decision Making Authorities DP JD Sr Medical Director ISS DP JD Assistant Medical Director ISS DP JD Medical Director ISS	Full	The requirement is met in: Decision Making Authorities DP JD Sr. Medical Director ISS, DP JD Assistant Medical Director ISS and DP JD Medical Director ISS. File Review Results: All (15) of the fifteen (15) grievance files reviewed onsite documented the date of the grievance, and provided notice in a manner and format that is easily understood.	
13.4.5	**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	A-LA 3100.70 Member Appeals pg. 9	Full	The requirement is met in A-LA 3100.70 Member Appeals pg. 9.	

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
	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.				
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.	A-LA 3100.70 Member Appeals, pg. 4 Appeal Resolution Letter Denial Appeal Resolution Letter Approval	Full	The requirement is met in the P/P A-LA 3100.70 Member Appeals, pg. 4, and in the template letters: Appeal Resolution Letter Denial, And Appeal Resolution Letter Approval. File Review Results: Out of the ten (10) appeal files reviewed, six (6) denials were upheld. All six (6) upheld denial files demonstrated evidence of notification of right to a State Fair Hearing and how to do so.	
13.5	**Notice 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.	A-LA 7100.05 Prior Authorization, pg. 19	Substantial	The requirement is addressed in A-LA 7100.05 Prior Authorization, pg. 19 but does not appear to be in any notice. Recommendation: A template Notice of Action letter or other documentation should be provided for review.	
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;	A-LA 7100.05 Prior Authorization pg. 19	Full	The P/P A-LA 7100.05 Prior Authorization pg. 19 addresses this element. A template letter for Notice of Action on prior authorizations was not submitted for review. File Review Results: All fifteen (15) of the fifteen (15) grievance files reviewed onsite stated the results of the resolution	

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
				process and the action the MCO intended to take.	
13.5.2.2	The reasons for the action;	A-LA 7100.05 Prior Authorization pg. 19	Full	The P/P A-LA 7100.05 Prior Authorization pg. 19 addresses this element. A template letter for Notice of Action on prior authorizations was not submitted for review. File Review Results: All fifteen (15) of the 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;	A-LA 7100.05 Prior Authorization pg. 19	Full	The P/P A-LA 7100.05 Prior Authorization pg. 19 addresses this element.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	A-LA 7100.05 Prior Authorization pg. 20	Full	The P/P A-LA 7100.05 Prior Authorization pg. 20 addresses this element.	
13.5.2.5	The procedures for exercising the rights specified in this section;	A-LA 7100.05 Prior Authorization pg. 20	Full	The P/P A-LA 7100.05 Prior Authorization pg. 20 addresses this element.	
13.5.2.6	The circumstances under which expedited resolution is available and how to request it;	A-LA 7100.05 Prior Authorization pg. 20	Full	The P/P A-LA 7100.05 Prior Authorization pg. 20 addresses this element.	
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	A-LA 7100.05 Prior Authorization pg. 20	Substantial	The P/P A-LA 7100.05 Prior Authorization pg. 20 addresses this element. File Review Results: Of the ten (10) appeal files reviewed, none contained this language. This language is available in the member handbook. Recommendation: Notification of the member's right to continuation of benefits should be added to the appeal letter	

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
13.5.2.8	Oral interpretation is available for all languages and how to access it.	A-LA 7100.05 Prior Authorization, pg. 20	Full	The P/P A-LA 7100.05 Prior Authorization, pg. 20, and the Member Handbook, pg. 17 address this element.	
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:	A-LA 7100.05 Prior Authorization, pg. 18	Full	The requirement is met in A-LA 7100.05 Prior Authorization, pg. 18.	
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.	A-LA 3100.70 Member Appeals, pg. 5	Full	The required language is found in P/P A-LA 3100.70 Member Appeals, pg. 5, but not in a P/P for Notice of Action or Prior Authorization. Recommendation: The contract language should be added to a P/P for Notice of Action or Prior Authorization.	
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.	A-LA 3100.70 Member Appeals, pg.6	Full	The requirement is met in the P/P A-LA 3100.70 Member Appeals, pg.6.	
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	A-LA 3100.90 Member Grievances, pg. 7 Grievance Extension Letter Template	Full	The requirement is met in the P/P A-LA 7100.05 Prior Authorization, pg. 15 and in the templates: Grievance Extension Letter and	

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
	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.	Appeal Extension Letter Template A-LA 3100.70 Member Appeals, pg. 9 A-LA 7100.05 Prior Authorization, pg. 15		Appeal Extension Letter. File Review Results: None (0) of the fifteen (15) grievance files reviewed onsite involved an extension; file review results for this element are NA.	
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.	A-LA 3100.90 Member Grievances, pg. 8 A-LA 3100.70 Member Appeals, pg. 9 Grievance Extension Letter Template Appeal Extension Letter Template	Full	The requirement is met in the P/Ps A-LA 3100.90 Member Grievances, pg. 8, and A-LA 3100.70 Member Appeals, pg. 9, with evidence of implementation in the Grievance Extension Letter Template, and Appeal Extension Letter Template. File Review Results: None (0) of the fifteen (15) grievance files reviewed onsite involved an extension; file review results for this element are NA.	
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.	A-LA 7100.05 Prior Authorization, pg. 16	Full	The requirement is met in A-LA 7100.05 Prior Authorization, pg. 16.	
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 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.	A-LA 3100.70 Member Appeals, pg. 9	Full	A P/P for Notice of Action for Expedited Service Authorizations was not submitted for review. The contract language is found in the submitted P/P A-LA 3100.70 Member Appeals, pg. 9, but not found in Prior Authorizations Policy. It was suggested onsite that the intent of this requirement is to prevent an appeal, and the requirement would be better met in a policy for expedited service authorizations.	

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
				Recommendation: The MCO should consider adding the required language to an expedited service authorization policy.	
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.	Appeal Extension Letter Template Grievance Extension Letter Template A-LA 3100.90 Member Grievances, pg. 8 A-LA 3100.70 Member Appeals, pg. 9	Full	The P/P A-LA 7100.05 Prior Authorization, pg. 16, and the template letter Appeal Extension meet this requirement.	
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.	A-LA 3100.70 Member Appeals A-LA 3100.90 Member Grievances	Full	The requirement is met in A-LA 3100.70 Member Appeals and A-LA 3100.90 Member Grievances.	
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.	A-LA 3100.90 Member Grievances, pg.7	Full	The requirement is met in A-LA 3100.90 Member Grievances, pg.7. File Review Results: All fifteen (15) of the fifteen (15) grievance files reviewed onsite were compliant for timeliness.	
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.	A-LA 3100.70 Member Appeals, pg. 8	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 8. File Review Results: Ten (10) of ten (10) appeals files reviewed were resolved in a timely manner.	
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	A-LA 3100.70 Member Appeals, pg. 9	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 9.	

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.				
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from 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.	A-LA 3100.70 Member Appeals, pg.9 A-LA 3100.90 Member Grievances, pg. 7 Appeal Extension Letter Template Grievance Extension Letter Template	Full	The requirement is met in: A-LA 3100.70 Member Appeals, pg.9, A-LA 3100.90 Member Grievances, pg. 7, Appeal Extension Letter Template, and Grievance Extension Letter Template. File Review Results: None (0) of the fifteen (15) grievance files reviewed onsite involved extensions; file review results for this element are NA.	
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.	A-LA 3100.70 Member Appeals, pg. 9 A-LA 3100.90 Member Grievances, pg. 8 Appeal Extension Letter Template Grievance Extension Letter Template	Full	The requirement is met in: A-LA 3100.70 Member Appeals, pg. 9, A-LA 3100.90 Member Grievances, pg. 8, Appeal Extension Letter Template, and Grievance Extension Letter Template. File Review Results: None (0) of the fifteen (15) grievance files reviewed onsite involved extensions; file review results for this element are NA.	
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.	A-LA 3100.70 Member Appeals, pg.9 A-LA 3100.90 Member Grievances, pg. 9 Appeal Resolution Letter Denial Appeal Resolution Letter Approval	Full	The requirement is met in: A-LA 3100.70 Member Appeals, pg.9, A-LA 3100.90 Member Grievances, pg. 9, Appeal Resolution Letter Denial, and Appeal Resolution Letter Approval. File Review Results: All fifteen (15) of the fifteen (15) grievance files reviewed onsite had evidence of an acknowledgement of receipt in writing within five (5) days.	
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	A-LA 3100.70 Member Appeals, pg.14 Appeal Resolution Letter	Substantial	The requirement is addressed in the P/P A-LA 3100.70 Member Appeals, pg.14, and in the Member	

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
	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.	Denial Appeal Resolution Letter Approval		Handbook, pg. 35. The Element Language "member may be held liable for the cost of those benefits if the hearing," was not found in the Appeal Resolution template letter. File Review Results: Of the ten (10) appeal files reviewed, six (6) denials were upheld. All six (6) upheld denial files demonstrated evidence of notification of right to a State Fair Hearing and how to do so. However, resolution letters did not include the right to request benefits while hearing is pending and that the member may be held liable for costs. Although this language is available in the member handbook, it should be added to the resolution letter.	
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.	A-LA 3100.70 Member Appeals, pg. 15	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 15.	
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.	A-LA 3100.70 Member Appeals, pg. 4	Substantial	The element language "representative of a deceased member's estate" was not found in P/P A-LA 3100.70 Member Appeals, pg. 4. Recommendation: The required language should be added to a P/P for Fair Hearings.	
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	A-LA 3100.70 Member Appeals, pg. 13	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 13.	

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
	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 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.	A-LA 3100.70 Member Appeals, pg. 9 Provider Handbook, pg. 78	Substantial	The required language is found in the P/PA-LA 3100.70 Member Appeals, pg. 9, but was not found in the Provider Handbook, pg. 78. Recommendation: The required language should be added 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.	A-LA 3100.70 Member Appeals, pg. 9 Expedited Appeal Request Denial Letter Template	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 9 and in the Expedited Appeal Request Denial Letter Template.	
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.	A-LA 3100.70 Member Appeals, pg. 9	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 9.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests	A-LA 3100.70 Member Appeals, pg. 13	Full	The P/P A-LA 3100.70 Member Appeals, states on pg. 14: "may be submitted orally without member	

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
	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.			written consent." The MCO explained onsite that they allow oral without member written consent to start the expedited process as soon as possible, and include the language as an exception, as provided in the regulation. The requirement is met in the Member Handbook, pg. 47. IPRO confirmed onsite that member written consent was present in all reviewed files.	
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.	Appeal Acknowledgment Letter	Substantial	The MCO explained onsite that it is a verbal process to notify member as stated in P/P 3100.70 member appeals pg. 14, where the limited time for a member to present evidence is implied, but not stated. Recommendation: The element language and the MCO process to notify members verbally should be added to the appeals policy.	
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.	A-LA 3100.70 Member Appeals, pg. 13	Full	The requirement is met in A-LA 3100.70 Member Appeals. The Policy states on pg. 14 "may be submitted orally without member written consent" for an expedited appeal. See comments for element: 13.7.4.1.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	A-LA 3100.70 Member Appeals, pg. 9	Full	The requirement is met in P/P A-LA 3100.70 Member Appeals, pg. 9.	
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	A-LA 3100.70 Member Appeals, pg. 16	Full	The requirement is met in the P/P A-LA 3100.70 Member Appeals, pg.	

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
	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.			16, except the policy does not contain the language: "with the member's written consent." All contract language is stated in the Member Handbook, pg. 47. Recommendation: The contract language "with the member's written consent" should be added to the Appeals Policy.	
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 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.	A-LA 3100.70 Member Appeals, pg. 18	Full	The requirement is met in the P/P A-LA 3100.70 Member Appeals, pg. 18, and in the Member Handbook, pg. 47.	
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).	A-LA 3100.70 Member Appeals, pg. 18	Full	The requirement is met in the P/P A-LA 3100.70 Member Appeals, pg. 18, and in the Member Handbook, pg. 47.	

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**
13.9	**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 Contract: :ABH LA Provider Phys Group Template V.5.11.16, pg 4 Provider Handbook pgs. 76-77	Full	The requirement is met in Provider Contract: ABH LA Provider Phys Group Template V.5.11.16, pg 4, and in the Provider Handbook pgs. 76-77.	
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.	A-LA 3100.90 Member Grievances, pg. 9 Grievance State Report Template A-LA 3100.73 Reporting Process, pg.3	Full	The requirement is met in A-LA 3100.90 Member Grievances, pg. 9, Grievance State Report Template, and A-LA 3100.73 Reporting Process, pg.3. Post onsite: the MCO provided a screen shot confirming submission and provided actual reports for the RP.	
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.	A-LA 3100.70 Member Appeals, pg. 10	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 10.	
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.	A-LA 3100.70 Member Appeals, pg. 10	Full	The requirement is met in A-LA 3100.70 Member Appeals, pg. 10.	

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;	BH adult_phone survey script_v4ENGSPA2016.docx1-7 BH child_phone survey script_v4ENGSPA2016.docx1-8 1-2 9111975 Aetna_LA ProvSat Survey (11x17).pdf ---NA1-4 Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf1-5 Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf1-2 Member BH Survey Meeting Minutes.docx1-2 Member BH Survey Meeting Minutes.docx1-2 Provider Survey Meeting Minutes.docx5 2016 ABHLA Quality Management Program Description EQRO.pdf1-113 Intro/ 5 this document is dated January 2016 (on cover) but signature page has 3/16 with no signatures which is within the review period – see page 5 which appears to meet the requirement 2015 Annual QAPI Evaluation A14 this document is dated 3/31/16 and addresses evaluation of the 2015 QAPI Program. Would ask if there is a separate Quality Program	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan, with evidence of submission of these provided in a screen shot, and evidence of implementation of this requirement in the additionally referenced documents submitted. The MCO explained onsite that they did their own BH Adult and Child surveys this year, and that LDH will provide the MCO with the survey for next year.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Description from 2015 or is this based on the document dated Jan 2016? 2016 QAPI Work Plan.xlsx Agree would want to know if there was a 2015 work plan to review Post-onsite: A signed copy (pg. 80) 2016 ABHLA Quality Management Program Description EQRO.pdf1-113 as well as screen shots of 121 QAPI Program Description and Workplan Submission, and 121 QAPI Workplan-Program Submission			
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.	A-LA 8000.30 Review of Practitioner Office Medical Records.pdf pg. 1-8 BH adult_phone survey script_v4ENGSPA2016.docx pg. 1-7 BH child_phone survey script_v4ENGSPA2016.docx pg. 1-8 9111975 Aetna_LA ProvSat Survey (11x17).pdf ---NA pg. 1-2 Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf 1-4 Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf 1-5 Member BH Survey Meeting Minutes.docx 1-2 Provider Survey Meeting Minutes.docx 1-2 2015 Annual QAPI Evaluation pg. 5 2016 ABHLA Quality	Full	The requirement is met in the QAPI Program Description and Work Plan, with evidence of implementation provided in the additional Submitted documentation.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Management Program Description EQRO.pdf43-51 2016 QAPI Work Plan.xlsx 51-57 BH child_phone survey script_v4ENGSPA2016.docx 69-70 BH adult_phone survey script_v4ENGSPA2016.docx 55-57 9111975 Aetna_LA ProvSat Survey (11x17).pdf ---NA Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf AE19868_Aetna BH_Adult_Survey_IS13592_2015.pdf AE19869_Aetna BH_Child_Survey_IS13591_2015.pdf August 2016 PIP update.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Clinical Practice Guidelines_Website.pdf IPRO_FTPSite_Uploads.pdf Member BH Survey Meeting Minutes.docx Performance Measure Tracking.pdf Performance Measure Tracking.xls Provider Survey Meeting Minutes.docx Provider Manual-LA.pdf 2016 QM Report Submissions.pdf 2016 QM Report Submissions.pdf A-LA 8000.30 Review of Practitioner Office Medical			

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Records.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg Minutes May 2016.pdf QMUM Mtg PPT April 2016.pdf QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT July 2016.pdf QMUM Mtg PPT March 2016.pdf QMUM Mtg PPT May 2016.pdf			
14.1.4	Detect and address underutilization and overutilization of services	2016 ABHLA Quality Management Program Description EQRO.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf Adult Wellness Screening STI Gift Card.pdf August 2016 PIP update.pdf Circumcision_Notice.pdf LARCS State Bulletin.pdf LARCS State Bulletin_website.pdf LEERS Pregnancy Report Screenshot.pdf PromiseProgram_Website.pdf ProviderCommunications_website.pdf UM CM Readmissions ER REPORTS CM Special Needs Pregnant Women HIV Sickle	Full	The 2016 ABHLA Quality Management Program Description EQRO.pdf pg. 5 and the QAPI Work Plan meet this requirement, with evidence of implementation in the submitted documents.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Cell .pdf UM-Prior Auth.pdf Adult Wellness Screening STI Gift Card.pdf			
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.	17P Bulletin.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf Circumcision_Notice.pdf LARCS State Bulletin_website.pdf ProviderCommunications_website.pdf UM CM Readmissions ER REPORTS CM Special Needs Pregnant Women HIV Sickle Cell .pdf UM-Prior Auth.pdf RFP CM STI LARCs SCD RFP_305PUR-DHHRFP_BH-MCO-2014-MVA_Aetna Better Health_Prematurity PIP RFP_305PUR-DHHRFP_BH-MCO-2014-MVA_Aetna Better Health_Special Needs	Full	The 2016 ABHLA Quality Management Program Description EQRO.pdf pg.40 contains contract language. The MCO explained onsite that LDH approved their strategies during the RFP process, and provided the RFP references as evidence of approval.	
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.	CM Special Needs Assessments Pregnant Women HIV Sickle Cell ADHD.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf this document makes a generic comment regarding detecting under-utilization but it does not specifically address the items listed in the requirement – see page 5 ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress	Full	The requirement is addressed in the 2016 QAPI Program description and met in the Performance Measure Tracking.xls Report.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf CM Special Needs Assessments Pregnant Women HIV Sickle Cell ADHD.pdf LARCS State Bulletin.pdf Performance Measure Tracking.pdf Performance Measure Tracking.xls PromiseProgram_Website.pdf UM CM Readmissions ER REPORTS CM Special Needs Pregnant Women HIV Sickle Cell .pdf			
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.	CM Special Needs Assessments Pregnant Women HIV Sickle Cell ADHD.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf ADHD First Fill Report.pdf ADHD Prior Authorization Guidelines_Web Location.pdf Clinical Practice Guidelines_Website.pdf Provider Manual-LA.pdf 2016 QAPI Work Plan.xlsx 2016 ABHLA Quality Management Program Description EQRO.pdf this document makes a generic comment regarding detecting over-utilization but it does not specifically address the items listed in the requirement – see page 5 121 QAPI Workplan-Program	Full	The requirement is addressed in the QAPI Program Description and Work Plan, and is met in the policy ADD-ADHD-Clinical-Guideline-LA-revised and MCO website link for providers to AAP guidelines.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Submission ADD-ADHD-Clinical-Guideline-LA-revised			
14.1.8	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	CM Special Needs Assessments Pregnant Women HIV Sickle Cell ADHD.pdf CSOC Report.pdf ICM Program Description.pdf ICM Program Description.pdf Members Special Health Care Needs Screenshot.pdf 2015 Annual QAPI Evaluation 2016 ABHLA Quality Management Program Description EQRO.pdf CM Special Needs Assessments Pregnant Women HIV Sickle Cell ADHD.pdf CSOC Report.pdf (template) ICM Program Description.pdf Members Special Health Care Needs Screenshot.pdf 2016 QAPI Work Plan.xlsx 313 CSOC Report All Qtrs / 313 ABH 2016 Q1, Q2, Q3	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan with evidence of evaluation in the 313 CSOC Reports All Qtrs / 313 ABH 2016 Q1, Q2, Q3.	
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.	PCMH - ASSESSMENT - Criteria.xls Market Overview.pdf 218 ABH 2015-2016	Full	The requirement is met in the submitted documents PCMH - ASSESSMENT - Criteria.xls and Market Overview.pdf, with evidence of implementation in the report 218 ABH 2015-2016.	
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	2016 ABHLA Quality Management Program Description EQRO.pdf 2015 Annual QAPI Evaluation.pdf 2016 QAPI Work Plan.xlsx 2015 Population Assessment.pdf Member Language and Ethnicity Report.pdf	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description EQRO.pdf with a description of the methodology and evidence of reporting provided in the Member Language & Ethnicity Source/Report.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	geography at the request of DHH.	Demographic Member Data SQL.pdf 2015 Population Assessment.pdf – see page 1 "data sources and methodology" Member Language & Ethnicity Source/Report			
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.	9 5 14_Readmission Reduction Programxx (2) (2).doc Chronic Condition Management - Hep C Standard Template.docx Chronic Condition Management - HIV Standard Template.docx DRAFT CCMP_Sickle Cell Anemia 5 14 15.docx Pregnancy- Standard Template.docx 2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 ABHLA QAPI Program Description and Work Plan with additional evidence of implementation provided.	
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.	Prior Authorization Process 7100 05 Desktop.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf HEDIS WORKPLAN.xlsx Provider Manual-LA.pdf Provider Manual-LA.pdf 2016 QAPI Work Plan.xlsx QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes June 2016.pdf	Full	The requirement is met in the QAPI Program Description and Work Plan, with evidence of implementation in the submitted QMUM meeting minutes and HEDIS 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**
		QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT July 2016.pdf QMUM Mtg PPT June 2016.pdf QMUM Mtg PPT November 2015.pdf			
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.	ABH(LA) Board Consent 10-5-16 (Grant).pdf ABH(LA) Board Consent 10-5-16.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf ABH(LA) Board Consent 10-5-16 (Grant).pdf ABH(LA) Board Consent 10-5-16.pdf	Full	The requirement is met in the QAPI Program Description and Work Plan and in the submitted documentation: ABH(LA) Board Consent 10-5-16 (Grant).pdf ABH(LA) Board Consent 10-5-16.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf ABH(LA) Board Consent 10-5-16 (Grant).pdf ABH(LA) Board Consent 10-5-16.pdf	
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.	BH adult_phone survey script_v4ENGSPA2016.docx BH child_phone survey script_v4ENGSPA2016.docx 9111975 Aetna_LA ProvSat Survey (11x17).pdf ---NA Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Member BH Survey Meeting Minutes.docx Provider Survey Meeting Minutes.docx BH adult_phone survey script_v4ENGSPA2016.docx BH child_phone survey script_v4ENGSPA2016.docx 9111975 Aetna_LA ProvSat Survey (11x17).pdf ---NA Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data	Full	The requirement is met in the BH survey scripts (Adult and Child) the CAHPS Reports, Provider Survey, and QMUM 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**
		Submission.pdf AE19868_Aetna BH_Adult_Survey_IS13592_2015.pdf AE19869_Aetna BH_Child_Survey_IS13591_2015.pdf Appeals Website.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf LA Member Advisory Council Plan (5).pdf Member BH Survey Meeting Minutes.docx Provider Manual-LA.pdf Provider Survey Meeting Minutes.docx 2016 QAPI Work Plan.xlsx QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes June 2016.pdf QMUM Mtg Minutes May 2016.pdf Screenshot_MAC_Website.pdf			
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.	Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf CAHPS Soft Skills Training.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf CSI 111715-MINUTES.docx 2015 Annual QAPI Evaluation.pdf	Full	The requirement is met in the QM Report Screenshots as evidence of disseminating the referenced quality findings, actions and evaluations of effectiveness.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		2016 ABHLA Quality Management Program Description EQRO.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf CAHPS Soft Skills Training.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf CSI 111715-MINUTES.docx 2016 QAPI Work Plan.xlsx QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes June 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg Minutes May 2016.pdf QMUM Mtg Minutes October 2015.pdf QMUM Mtg PPT April 2016.pdf QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT July 2016.pdf QMUM Mtg PPT June 2016.pdf QMUM Mtg PPT March 2016.pdf QMUM Mtg PPT May 2016.pdf QMUM Mtg PPT November 2015.pdf 121 QAPI Program Description and Workplan Submission.pdf			

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		2016 QM Report Submissions.pdf CAHPS Evidence of Submission.pdf			
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.	ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA-revised.pdf ADHD Clinical Practice Guideline.pdf ADHD First Fill Report.pdf ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf Clinical Practice Guidelines_Website.pdf Provider Manual-LA.pdf 2016 QAPI Work Plan.xlsx CPG on AETNA Website ADD-ADHD peds.2011-2654	Full	The requirement is met in the policy ADD-ADHD-PA-Clinical-Guideline-LA-revised.pdf with evidence of dissemination of the American Academy of Pediatricians ADHD CPGs to providers in the link CPG on AETNA Website ADD-ADHD peds.2011-2654. The MCO also stated onsite that they are addressing this requirement in the BH survey as well as conducting provider audits.	
14.1.18	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	UM Peer to Peer.pdf DP_UM Program Description-signed ISS 093016.pdf P2P Report.pdf	Full	The requirement is met in UM Peer to Peer.pdf. , DP_UM Program Description-signed ISS 093016.pdf, and P2P Report.pdf.	
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.	PIP Outlook Meeting Schedule.pdf State PIP Meeting Materials Screenshot.pdf State PIP Meeting Minutes_2016_07.pdf State PIP Meeting Minutes_2016_07.pdf School Health Collaborative Mtg School Health Collaborative Webinar Judge Stansbury Mtg Calendar Judge Stansbury Obesity Prevention Meeting	Full	The requirement is met in the following screenshots providing evidence of participation in IMT meetings: School Health Collaborative Mtg School Health Collaborative Webinar Judge Stansbury Mtg Calendar Judge Stansbury Obesity Prevention Meeting LDH November Meeting Agenda Incarcerated Population Members LA DOC Attendees Healthy BR Committee Mtg.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		LDH November Meeting Agenda Incarcerated Population Members LA DOC Attendees Healthy BR Committee Mtg			
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.	Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx CSOC Report.pdf	Full	The requirement is met in the following reports: First Fill Effectiveness_2016_12_08, 313 ABH 2016 Q1-Q4, 319 Fidelity Monitoring Report Q1-Q3, 2016 YTD Metrics Outcomes 12.5.16, and Performance Measure Tracking as detailed in the 2016 updated Final LA Performance Measure Submission guide_8_2.	
	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.		N/A		
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;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf, with evidence of an interim medical director in the 2015_Q4 and 3-30-16 1Q, QMOC meeting minutes, and chief medical officer in the QMOC Meeting Minutes 6-30-16 Q2.	
14.2.1.2	The MCO Behavioral Health Director;	2016 ABHLA Quality Management Program Description EQRO.pdf	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf, with evidence	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2		of the BH MD in attendance at the QMOC Meeting Minutes_ 2015_Q4, and QMOC Meeting Minutes 6-30-16 Q2.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2	Full	The requirement is met in the 2016 QAPI Program Description, the QMOC Charter.pdf, and in the QMOC meeting minutes.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf. A member advocate was present at the QMOC Meeting as documented in the Minutes_ 2015_Q4.	
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 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf. In the submitted QMOC meeting minutes for 2015 Q4 and 2016 Q1, a LDH representative attended via WebEx; the designated LDH member is documented as absent for the 2016 Q2 meeting.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf., with evidence of implementation provided in the	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		QMOC Charter.pdf ABH_QMOC Meeting Minutes_ 2015_Q4 ABH_QMOC Meeting Minutes 3-30-16 1Q ABH_QMOC Meeting Minutes 6-30-16 Q2		submitted meeting minutes.	
14.2.2.1	Direct and review quality improvement (QI) activities;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 QAPI Program Description, Work Plan and the QMOC Charter.pdf.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 QAPI Program Description, Work Plan and the QMOC Charter.pdf	
14.2.2.3	Review and suggest new and or improved QI activities;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf ABH_QMOC Meeting Minutes 3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 QAPI Program Description, Work Plan and the QMOC Charter.pdf., with evidence of implementation in the submitted meeting minutes.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf 2016 QAPI Work Plan.xlsx ABH_QMOC Meeting Minutes 3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf	Full	The requirement is met in the 2016 QAPI Program Description, Work Plan and the QMOC Charter.pdf., with evidence of implementation in the submitted meeting minutes.	
14.2.2.5	Designate evaluation and study design procedures;	2016 ABHLA Quality Management Program Description EQRO.pdf QMOC Charter.pdf 2016 QAPI Work Plan.xlsx ABH_QMOC Meeting Minutes	Full	The requirement is met in the 2016 QAPI Program Description, Work Plan, and the QMOC Charter.pdf., with evidence of implementation in the submitted meeting minutes and 2015 Program Evaluation.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf 2015 Annual QAPI Eval 3.31.16 Final version			
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	2016 ABHLA Quality Management Program Description EQRO.pdf PCP Performance Reporting.pdf QMOC Charter.pdf Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx 319 Fidelity Monitoring Report Q2-Q3 069 ABH 2016 Q1 069 ABH Q3 2016 Medical Record Review Report	Full	The requirement is met in the 2016 QAPI Program Description and the QMOC Charter.pdf, with evidence of implementation in the 319 Fidelity Monitoring Report Q2-Q3 and quarterly 069 ABH 2016 Medical Record Review Reports.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	2016 ABHLA Quality Management Program Description EQRO.pdf ABH_QMOC Meeting Minutes 3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes June 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg Minutes May 2016.pdf QMUM Mtg Minutes October 2015.pdf QMUM Mtg PPT April	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan, with evidence of implementation provided in the submitted QMUM and QMOC 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
		2016.pdf QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT July 2016.pdf QMUM Mtg PPT June 2016.pdf QMUM Mtg PPT March 2016.pdf QMUM Mtg PPT May 2016.pdf QMUM Mtg PPT November 2015.pdf			
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx ABH_QMOC Meeting Minutes 3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan with evidence of implementation in the submitted meeting minutes.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;	2016 ABHLA Quality Management Program Description EQRO.pdf ABH_QMOC Meeting Minutes 3-30-16 1Q.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf ABH_QMOC Meeting Minutes_ 2015_Q4.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes June 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg Minutes May 2016.pdf QMUM Mtg Minutes October 2015.pdf	Full	The requirement is met in the QAPI Program Description with evidence of implementation in the submitted QMOC and QMUM meeting minutes; confirmation of submission to LDH is provided in QM reports screenshots of upload.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Post-onsite: QM Report Screenshots Report 120 2016 QAPI Program and QM Workplan screenshot of upload			
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;	2015 Annual QAPI Evaluation.pdf pgs. 96-97 Effectiveness of Care Management 2016 ABHLA Quality Management Program Description EQRO.pdf QMUM Mtg Minutes June 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg Minutes October 2015.pdf QMUM Mtg PPT June 2016.pdf QMUM Mtg PPT March 2016.pdf	Full	The 2016 Program Description and the 015 Annual QAPI Evaluation.pdf, pgs. 96-97, meet this requirement.	
14.2.2.11	Ensure that the QAPI committee chair attends DHH quality meetings; and	2016 ABHLA Quality Management Program Description EQRO.pdf Screenshot of Aetna Better Health Chief Medical Officer attending LDH.docx	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, with evidence of implementation in the Screenshot of Aetna Better Health Chief Medical Officer attending LDH.docx	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	2016 ABHLA Quality Management Program Description EQRO.pdf Provider Manual-LA.pdf QMUM Mtg Minutes August 2016.pdf	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description EQRO.pdf, pg. 18, and Provider Manual, pg. 9.	
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,	2016 ABHLA Quality Management Program Description EQRO.pdf 121 QAPI Program Description and Workplan Submission.pdf 2016 QAPI Work Plan.xlsx 2016 121 QAPI Program Description Peggy Screenshot	Full	The requirement is met in the 2016 QAPI Program Description and Work Plan with evidence of submission to LDH in the screen shot: 121 QAPI Program Description and Workplan Submission.pdf.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	at a minimum, shall:				
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	2015 Annual QAPI Evaluation.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2015 Annual QAPI Evaluation.pdf, 2016 ABHLA Quality Management Program Description EQRO.pdf, and 2016 QAPI Work Plan.xlsx	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	2015 Annual QAPI Evaluation.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2015 Annual QAPI Evaluation.pdf, 2016 ABHLA Quality Management Program Description EQRO.pdf, and 2016 QAPI Work Plan.xlsx	
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 ABHLA Quality Management Program Description EQRO.pdf (language on pg. 18 without specifics) 2016 QAPI Work Plan.xlsx Post-onsite 2016 QAPI Work Plan Staff Credentials 218 ABH 2015-2016 2015 LA QAPI Medicaid Workplan 2015 Annual QAPI Eval 3.31.16 PM edits-LRsigned 2015 QAPI Program Description LR ABH(LA) Board Consent 10-5-16 (Grant) ABH(LA) Board Consent 10-5-16	Full	The 2016 QAPI Program Description pgs. 18, and 35-39 detail all elements of this requirement, including the credentials/licensure requirements for all staff positions, with evidence of implementation provided in 2016 QAPI Work Plan Staff. Credentials; the MCO submitted evidence of implementation for 2015 in additionally referenced documents.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	2015 QM UM Committee Charter.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes June 2016.pdf	Full	The requirement is met in the 2015 QM UM Committee Charter.pdf, and 2016 ABHLA Quality Management Program Description, with evidence of implementation in the submitted 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
		QMUM Mtg Minutes May 2016.pdf			
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 ABHLA Quality Management Program Description EQRO.pdf	Full	The 2016 QAPI Program Description and Work Plan are exclusive to LA, meeting this 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.	Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx Aetna Fidelity Monitoring_MST MOU 05012016 (3)-signed.pdf Aetna Fidelity Monitoring _FFT MOU (3)-signed.pdf MOU for fidelity monitoring agency-ABH Homebuilders.docx 2016 ABHLA Quality Management Program Description EQRO.pdf 319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED.docx ABH-LA 8000.01 QAPI Evaluation A-LA 7000.30 Approval Process of Medical Necessity Criteria A-LA 8000.34 Practitioner and Provider Performance Data 319 Fidelity Monitoring Report	Full	The requirement is met in Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx, Aetna Fidelity Monitoring_MST MOU 05012016 (3)-signed.pdf, Aetna Fidelity Monitoring _FFT MOU (3)-signed.pdf, MOU for fidelity monitoring agency-ABH Homebuilders.docx, 2016 ABHLA Quality Management Program Description, pg. 10, and 319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED.docx.	
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.	2016 ABHLA Quality Management Program Description EQRO.pdf, pg. 10 319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED.docx	Full	The requirement is met in 2016 ABHLA Quality Management Program Description pg. 10, and 319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED.docx.	
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	2015 Annual QAPI Evaluation.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf 2016 QAPI Work Plan.xlsx	Full	The requirement is met in the 2016 QAPI Program Description and 2015 Program Evaluation, with evidence of implementation and submission provided in additional submitted documents and screenshots.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	impact and effectiveness of the QAPI program.	2016 QM Report Submissions.pdf 2016 QM Report Submissions.pdf Executive Summary Quality management / QAPI Annual Evaluation Annual Quality Management Evaluation / 10 – 11 Quality Management Structure / QAPI Program Description / Sheet 1 2016 119 Report Submissions (Quarterly) Page 3 2016 069 Report Submissions (Quarterly) Page 1 This looks similar to 14.1.1.2 on page 1 (copy answer from above)			
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 ABHLA Quality Management Program Description EQRO.pdf 2016 QM Report Submissions.pdf Annual Quality management Evaluation / 10 – 11 2016 319 Report Submissions (Quarterly) Fidelity Monitoring Page 4 320 Report / 320 ABH 2016 Q3 313 Reports / 313 ABH 2016 Q1-Q4 318 Report / 318 ABH 2016 Q3 317 Reports PASRR / 317 ABH 2016 Q3 323 Reports / 323 ABH 2016 05 329 Reports / 329 ABH 2016 Q1-Q3 319 Reports / 319 ABH 2016 Q2-Q3	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description EQRO, with evidence of implementation in the following referenced reports: 320, 313,318, 317, 323, and 329 and with evidence of submission in the 2016 QM Report Submissions.pdf.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.2.5 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.*	Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf Supplemental Monthly Measure Reporting Template OCT 2013 2016 YTD Metrics Outcomes 12.5.16 Performance Measure Tracking 2016 updated Final LA Performance Measure Submission guide_8_2	Full	The requirement is met in the referenced HEDIS and PM results reports. The MCO stated onsite that they reported the PMs specified in the MCO Quality Companion Guide required for their first year of reporting. The MCO also stated that the Behavioral Health Companion Guide has been released by LDH, but regulations related to it have not yet been released.	
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	Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf 2016 ABHLA Quality Management Program	Full	The requirement is met as noted above. It is unclear whether Appendix J reference should remain in the requirement; the MCO should clarify the status of Appendix J with LDH.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.	Description EQRO.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf Supplemental Monthly Measure Reporting Template OCT 2014 2016 YTD Metrics Outcomes 12.5.16 Performance Measure Tracking 2016 updated Final LA Performance Measure Submission guide_8_2			
14.2.5.3	The MCO shall have processes in place to monitor and self-report all performance measures.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf ABH_QMOC Meeting Minutes 6-30-16 Q2.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes August 2016.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg Minutes March 2016.pdf QMUM Mtg PPT April 2016.pdf QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT July 2016.pdf QMUM Mtg PPT March 2016.pdf Focus/Disposition HEDIS Measure Updates Page 3 Review of Performance Improvement Projects - Page 4 / HEDIS, 2016 Update Page	Full	The requirement is met in the 2016 QAPI Program Description, pg. 16 and the P/Ps A-LA 8000.34 Practitioner and Provider Performance Data, and A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects. The HEDIS work plan provides evidence of implementation in addition to the other PM documents submitted.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		16 Review of HEDIS Measures Page 22 HEDIS 2015 Rates Page 11 HEDIS Work Plan and Project Updates Page 21 Performance Improvement Project Updates Page 5/ 2015 HEDIS Project Measures Update Page 14 HEDIS Measures Page 44 2015 HEDIS Rates (reported in 2016) Page 9 / Performance Improvement Projects Page 13 HEDIS Work Plan/ Project Updates Page 21 A-LA 8000.34 Practitioner and Provider Performance Data			
14.2.5.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf IPRO_FTPSite_Uploads.pdf	Full	The requirement is met in the screenshot IPRO_FTPSite_Uploads.pdf.	
14.2.5.5	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	IPRO_FTPSite_Uploads.pdf	Full	The requirement is met in the screenshot IPRO_FTPSite_Uploads.pdf.	
14.2.5.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Clinical Practice Guidelines_Website.pdf Performance Measure Tracking.xls QMUM Mtg Minutes August 2016.pdf QMUM Mtg PPT August 2016.pdf QMUM Mtg PPT November 2015.pdf All All Review of Preventive Services Guidelines Page 6 Preventive Service Guidelines Page 13	Full	The requirement is met in the P/Ps A-LA 8200.05 HEDIS pgs. 4-8 and A-LA 8000.32 Practitioner Provider Oversight, pg. 5.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Integrated Biopsychosocial Model of Care Management Page 5 / BH Clinical Practice Guidelines Page 29 A-LA 8200.05 HEDIS pgs. 4-8 A-LA 8000.32 Practitioner Provider Oversight			
14.2.5.7	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	326 ABH 2016 08 Adverse Incident Report.xlsx CSOC Report.pdf QSI Gaps In Care QNXT Reporting.pdf 069 ABH Q3 2016 Medical Record Review Report.xlsx 14.2.5.13 PQoC System.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf 326 ABH 2016 08 Adverse Incident Report.xlsx Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx A-LA QM 63 Review of Potential Quality of Care Concerns.pdf CSOC Report.pdf Performance Measure Tracking.pdf QSI Gaps In Care QNXT Reporting.pdf A-LA 8000.32 Practitioner Provider Oversight.pdf A-LA 8000.34 Practitioner and Provider Performance Data.pdf A-LA 8200.05 HEDIS	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, pg. 14 with additional policies referenced meeting this requirement, including, A-LA 8200.05 HEDIS, and referenced reports indicating implementation of requirement.	
14.2.5.8	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	2016 ABHLA Quality Management Program Description EQRO.pdf Performance Measure Logic.pdf LA_2016-10_Gaps in Care	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, pg. 14 with evidence of implementation in the LA_2016-10_Gaps in Care Report.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Report			
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 "$$".	Performance Measure Tracking.pdf Q1 2016 QMUM DHH Business Review.pdf 2016 YTD Metrics Outcomes 12.5.16 Performance Measure Tracking	Full	The requirement is met in the 2016 YTD Metrics Outcomes 12.5.16 and Performance Measure Tracking results reports.	
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 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.	A-LA 8000.01 Quality Assessment Performance Improvement QAPI Program Evaluation.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf, pg. 10	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, pg. 10.	
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	2016 ABHLA Quality Management Program Description EQRO.pdf Final Auditor Statement HEDIS MRR Project 2016.pdf HEDIS 2016 IDSS Request Form_LA_FINAL.pdf Final Auditor Statement HEDIS MRR Project 2016.pdf HEDIS 2016 IDSS Request Form_LA_FINAL.pdf IPRO_FTPSite_Uploads.pdf 2016 YTD Metrics Outcomes 12.5.16 Performance Measure	Full	The requirement is met in the Final Auditor Statement HEDIS MRR Project 2016.pdf, and results reports 2016 YTD Metrics Outcomes 12.5.16 and Performance Measure Tracking with evidence of submission in the screenshot IPRO_FTPSite_Uploads.pdf.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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.	Tracking			
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.	A-LA 8000.01 Quality Assessment Performance Improvement QAPI Program Evaluation.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Performance Measure Tracking.pdf 121 QAPI Workplan-Program Submission	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, pgs. 13-14.	
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	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf Screenshot of CMO and QM Director attendance of July 21 2016 LDH QM mtg.pdf 2016 ABHLA Quality Management Program Description EQRO.pdf Medicaid Medical Director Meeting 072116.docx Screenshot of CMO and QM Director attendance of July 21 2016 LDH QM mtg.pdf Screenshot of CMO and QM Director attendance of July 21 2016 LDH QM mtg.pdf QSI Gaps In Care QNXT Reporting.pdf A-LA 8000.30 Review of Practitioner Office Medical Records.pdf 14.2.5.13 PQoC System.pdf Aetna ProReport Navigation	Full	The requirement is met in the 2016 ABHLA Quality Management Program Description, pgs. 13-14.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Guide for Providers LOUISIANA PLAN (2).pdf A-LA QM 63 Review of Potential Quality of Care Concerns.pdf MRR Assessment Tool - 8000 30T.pdf QSI Gaps In Care QNXT Reporting.pdf A-LA 8000.34 Practitioner and Provider Performance Data.pdf			
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.	QSI Gaps In Care QNXT Reporting.pdf A-LA 8000.30 Review of Practitioner Office Medical Records.pdf 14.2.5.13 PQoC System.pdf Aetna ProReport Navigation Guide for Providers LOUISIANA PLAN (2).pdf A-LA QM 63 Review of Potential Quality of Care Concerns.pdf MRR Assessment Tool - 8000 30T.pdf A-LA 8000.34 Practitioner and Provider Performance Data.pdf Provider Profile Report_Download&Output LA_2016-10_Gaps in Care Report	Full	The requirement is met in the policy A-LA 8000.34 Practitioner and Provider Performance Data.pdf, and the template MRR Assessment Tool - 8000 30T.pdf with evidence of implementation and report submission in the LA_2016-10_Gaps in Care Report and Provider Profile Report_Download&Output screenshot, respectively.	
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.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf	Full	The MCO submitted to IPRO all requested ADHD PIP components as well as the Prematurity PIP baseline report, meeting this requirement.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf	Full	The requirement is met as noted above in 14.2.8.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		ADHD Clinical Practice Guideline.pdf ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf	Full	The requirement is met as noted above in 14.2.8.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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.	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf ADHD Member Medicine Follow Ups Visits.pdf	Full	The requirement is met as noted above in 14.2.8.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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; • 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;	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf	Full	The requirement is met as noted above in 14.2.8.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	• 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.	ADHD Progress Report_2016_08_24.pdf August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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	A-LA 8400.05 Quality Improvement Activities_Performance Improvement Projects.pdf 17P Bulletin.pdf 17P_Monthly_2016_08 2015 Year End Prematurity PIP Data.xlsx ABHLA_ADHD_Mbr_Continuation_Letter Followup_Child.pdf ADD-ADHD-PA-Clinical-Guideline-LA.pdf ADHD Clinical Practice Guideline.pdf ADHD Member Medicine Follow Ups Visits.pdf ADHD Prior Authorization Guidelines_Web Location.pdf ADHD Progress Report_2016_08_24.pdf	Full	The requirement is met as noted above in 14.2.8.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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; • 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.	August 2016 PIP update.pdf Bayou_Health_Plan_Aetna Prematurity PIP Report_7_25_2016.pdf Clinical Practice Guidelines_Website.pdf DecisionFlowChart_PretermHighRiskHistory.pdf IPRO LA Prematurity Report - October 2015 IPRO_FTPSite_Uploads.pdf Performance Measure Tracking.pdf ProviderCommunications_Website.pdf QMUM Mtg Minutes April 2016.pdf QMUM Mtg Minutes July 2016.pdf Supplemental Monthly Measure Reporting Template OCT 2015			
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.	A-LA 8200.10 Member Satisfaction Surveys.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf	Full	The requirement is met in A-LA 8200.10 Member Satisfaction Surveys.pdf, Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, and Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf	
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.	A-LA 8200.10 Member Satisfaction Surveys.pdf FA_SCH_037_LA_CenterStudyServ_2001_111914_CSS_Survey_Master_Contract.pdf, pg. 3 contract is in effect through August 31, 2017.	Full	The requirement is met in FA_SCH_037_LA_CenterStudyServ_2001_111914_CSS_Survey_Master_Contract.pdf, pg. 3, which states the contract is in effect through August 31, 2017.	
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	A-LA 8200.10 Member Satisfaction Surveys.pdf Adult Medicaid Survey Results	Full	The requirement is met in the P/P A-LA 8200.10 Member Satisfaction Surveys.pdf,	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	survey results are due with all other performance measures.	Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Upload of CAHPS Results.msg		Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, and Upload of CAHPS Results.msg.	
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 shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	A-LA 8200.10 Member Satisfaction Surveys.pdf Upload of CAHPS Results.msg Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf	Full	The requirement is met in P/P A-LA 8200.10 Member Satisfaction Surveys.pdf, Upload of CAHPS Results.msg Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, and Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	A-LA 8200.10 Member Satisfaction Surveys.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf FA_SCH_037_LA_CenterStudy Serv_2001_111914_CSS_Surv ey_Master_Contract.pdf	Full	The requirement is met in P/P A-LA 8200.10 Member Satisfaction Surveys.pdf, Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, and FA_SCH_037_LA_CenterStudyServ_ 2001_111914_CSS_Survey_Master_ Contract.pdf.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	A-LA 8200.10 Member Satisfaction Surveys.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf QMUM Mtg Minutes July 2016.pdf QMUM Mtg PPT July 2016.pdf	Full	The requirement is met in the Power Point presentation Strategy Meeting 7.8.16LAR and 2015 and 2016 Executive Summary which provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Strategy Meeting 7.8.16LAR (Power Point) 2016 YTD Metrics Outcomes 12.5.16 Performance Measure Tracking 2015 and 2016 Executive Summary			
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.	A-LA 8200.10 Member Satisfaction Surveys.pdf Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf	Full	The requirement is met in A-LA 8200.10 Member Satisfaction Surveys.pdf, Adult Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf, and Child Medicaid Survey Results Report - NCQA HEDIS 2016 CAHPS 5.0 Data Submission.pdf.	
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.	BH adult_phone survey script_v4ENGSPA2016.docx BH child_phone survey script_v4ENGSPA2016.docx Member BH Survey Meeting Minutes.docx AE19869_Aetna BH_Child_Survey_IS13591_2015.pdf	Full	The requirement is met in the BH survey scripts and survey meeting minutes. The MCO explained onsite that they received approval from LDH to conduct their own survey this year and for next year will use the LDH survey if it's ready.	
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.	Aetna Better Health of Louisiana NCQA Agreement 234984H-16 EXECUTED AL 4.15.2016.pdf Confirmation Letter NCQA Aetna Better Health of Louisiana 234984H-16.pdf ISS Submission for NCQA.pdf NCQA Confirmation Letter Email.pdf	Full	The submitted documents provide evidence of implementing the necessary steps to meet this requirement. The MCO stated onsite that they are on track to meet this requirement of attaining accreditation. Recommendation: The MCO should provide evidence of meeting this requirement when available.	
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	Aetna Better Health of Louisiana NCQA Agreement 234984H-16 EXECUTED AL 4.15.2016.pdf	Full	The submitted NCQA Confirmation Letter Email.pdf Dated April 15, 2016 provides evidence of MCO application for	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	regarding the application process and the accreditation requirements.	Confirmation Letter NCQA Aetna Better Health of Louisiana 234984H-16.pdf ISS Submission for NCQA.pdf NCQA Confirmation Letter Email.pdf Aetna Better Health of Louisiana NCQA Agreement 234984H-16 EXECUTED AL 4.15.2016.pdf		accreditation by NCQA, and submission of correspondence with NCQA meets this requirement.	
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.	Aetna Better Health of Louisiana NCQA Agreement 234984H-16 EXECUTED AL 4.15.2016.pdf Confirmation Letter NCQA Aetna Better Health of Louisiana 234984H-16.pdf ISS Submission for NCQA.pdf NCQA Confirmation Letter Email.pdf Aetna Better Health of Louisiana NCQA Agreement 234984H-16 EXECUTED AL 4.15.2016.pdf	N/A	As noted above, the MCO is on track to 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.	LA Member Advisory Council Plan (5).pdf MAC_Committee_Q2_mtg_notes_5_17_16 MAC_Committee_Q3_mtg_notes_8_16_16 MAC_Q1_3_29_MtgNotes	Full	The requirement is met in the LA Member Advisory Council Plan (5) with evidence of MAC meetings in the submitted meeting notes.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	LA Member Advisory Council Plan (5).pdf MAC_Committee_Q2_mtg_notes_5_17_16 MAC_Committee_Q3_mtg_notes_8_16_16 MAC_Q1_3_29_MtgNotes	Full	The requirement is met in the LA Member Advisory Council Plan (5) with evidence of MAC meetings in the submitted meeting notes.	
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	LA Member Advisory Council Plan (5).pdf MAC_Committee_Q2_mtg_notes_5_17_16 MAC_Committee_Q3_mtg_notes_8_16_16	Substantial	The requirement language is found in LA Member Advisory Council Plan (5), pg. 5. Evidence of at least one family member/caregiver of a child with special health care needs having representation on the	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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 membership.	MAC_Q1_3_29_MtgNotes		committee, and members as 50% of membership was not provided or evident in the submitted meeting notes. Recommendation: The MCO should provide evidence of MAC composition in compliance with 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.	LA Member Advisory Council Plan (5).pdf	Substantial	The requirement language is found in LA Member Advisory Council Plan (5), pg.6. Recommendation: The MCO should provide training attendee lists and evidence of ongoing training.	
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.	LA Member Advisory Council Plan (5).pdf 141 Report Submission.pdf 141 ABH 2015 Jan Dec.pdf	Full	The requirement is met in the LA Member Advisory Council Plan (5), with evidence of submission in 141 Report Submission.pdf.	
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.	LA Member Advisory Council Plan (5).pdf 2016 139 Report Submissions.pdf MAC 139 ABH 2016 Q2.pdf Screenshot_MAC_Website.pdf	Substantial	The requirement is addressed in the Screenshot_MAC_Website.pdf which shows agendas posted for MAC meetings. Evidence of all agenda and Council minutes posted to the MCO website in English and Spanish, with any member-identifying information redacted was not submitted for review. Recommendation: All MAC council minutes for the RP should be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	
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	319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED.docx Aetna Fidelity Monitoring	Full	The requirement is met in the 319 ABH 2016 Q2 Fidelity Monitoring Plan 8.1.16 FINAL APPROVED, with evidence of implementation in the	

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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**
	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.	_FFT MOU (3)-signed.pdf Aetna Fidelity Monitoring_MST MOU 05012016 (3)-signed.pdf Aetna MST Q2 2016 Fidelity Monitoring Report.xlsx MOU for fidelity monitoring agency-ABH Homebuilders.docx 2016 QM Report Submissions.pdf Institute for Family Service Homebuilders MOU_6-27-2016 319 Fidelity Monitoring report		MOUs (FFT, MST, and Homebuilders) and evidence of submission to LDH in the screenshot2016 QM Report Submissions.pdf.	
14.8	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral	326 ABH 2016 08 Adverse Incident Report.xlsx Adverse Incident ABHLA website screenshot.docx	Full	The requirement is met with in the P/P (Adverse Incident Reporting) with evidence of implementation in the 326 reports. The MCO stated	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	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.	Adverse Incident Reporting Action Plan April 2016 LAR version 8.15.16.docx AdverseIncidentReportingForm-LA 2016.pdf AdverseIncidentReportingInstructionsDefinitions-LA 2016.pdf Aetna Adverse Incident Reporting Desktop revised 2 22 16.docx A-LA 7000.55 Reporting Abuse Neglect Exploitation of Children...docx		onsite that the Behavioral Health Companion Guide drafted by LDH is not in effect for the RP.	

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.	System Screenshots of QNXT Dynamo CM and AG.docx Key Performance Indicator Report Member Ethnicity and Language Report Examples of Utilization Management Reports—188, 313, 318 Examples of Grievance and Appeals Reports—112, 113, 182	Full	The MCO provided a series of screenshots of the case management and appeals and grievances databases. Additionally, the MCO provided copies of reports covering member demographics, claims data, and utilization. The MCO provided examples of grievances and appeals reports, as well. Data were reported monthly and/or quarterly.	

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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 13. Meeting Notes Monthly SIU Call 2016	Full	The requirement is stated verbatim on page 13 of the MCO's Corporate Compliance Fraud/Waste/ Abuse Plan. The MCO submitted evidence of this requirement through Meeting Minutes from the monthly SIU calls.	
15.1.3	The MCO shall cooperate and assist the state and any state or federal agency charge 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 13. 002—MCD—SIU Overview	Full	The requirement is stated verbatim on page 13 of the MCO's Corporate Compliance Fraud/Waste/ Abuse Plan. The MCO also provided 002-MCD, which outlines the Special Investigation Unit's procedures for fraud, waste, and abuse investigation.	
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, papers, and records which are	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section VI, page 9.	Full	The requirement is stated verbatim on pages 9-10 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section VI, page 10.	Full	The requirement is stated verbatim on page 10 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section VI, page 10. A-LA 3100.70 Member Appeals A-LA 3100.73 Reporting Process	Full	The requirement is stated verbatim on page 10 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan. The MCO also provided 3100.70 and 3100.73 as evidence of the appeals and grievances processes and procedures.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14.	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
15.1.8	The MCO will report to DHH, within three (3) business days, when it is discovered that nay MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14.	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/ Abuse Plan.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	program to their designated Program Integrity contact.				
15.1.9	The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. A-LA 3000.41 Compliance Review and Monitoring	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan. The MCO also provided 3000.41 as evidence of the MCO's procedures in place to detect, prevent, and report fraud, waste, and abuse.	
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 accordance with timeframes specified 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. Aetna Better Health of Louisiana Facility Service Agreement, page 30	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan. The requirement is also addressed in the MCO's Compliance Addendum (agreement with providers/facilities), Section 2.16.	
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 a 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. Aetna Better Health of Louisiana Facility Service Agreement, page 6	Full	The requirement is addressed in the MCO's Compliance Addendum (agreement with providers/facilities), Section 2.2.	
15.1.12	The MCO shall have adequate staffing and resources to investigate unusual incidents and	CYE 16 ABH of LA Corporate Compliance FWA Plan Final,	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.	Section X, page 14. Medicaid SIU Team		Compliance Fraud/Waste/Abuse Plan. The MCO also provided a chart depicting the SIU team and the investigators for each state in which the MCO operates.	
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 provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. 010—MCD—Pursuing Recoveries Lost Fraud, Waste, or Abuse	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. 010—MCD—Pursuing Recoveries Lost Fraud, Waste, or Abuse	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
15.1.13.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. 010—MCD—Pursuing Recoveries Lost Fraud, Waste, or Abuse	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
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 or State litigation or investigation, or are being audited by the Louisiana RAC.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. 010—MCD—Pursuing Recoveries Lost Fraud, Waste, or Abuse	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.1.14	This prohibition described above in Section 15.1.3 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14.	Full	The requirement is stated verbatim on pages 14-15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 13.	Full	The requirement is stated verbatim on page 13 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.1.16	**Reporting and Investigating Suspected Fraud and Abuse**				
15.1.16.1	The MCO shall cooperate with all appropriate 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, §455.12, §455.21) both internally and for its subcontractors.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 13. 003—MCD Incoming Referrals and Initial Case Set Up 006 MCD Initial Case Opening & Actions by Investigator (TK) 026 MCD Collaboration with PBM on Pharmacy Cases	Full	The requirement is stated verbatim on page 13 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided several policies as evidence of the processes and procedures the plan has in place to identify, investigate, and referral of suspected fraud.	
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 the concerns and/or allegations of any tips are authenticated.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 145 ABH 2016 Report 005 MCD Typical Steps of an Investigation	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided evidence of a tracking sheet for all tips on suspected fraud/abuse, as well as 005-MCD, which outlines the steps of an investigation.	
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:	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 145 ABH 2016 Report	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided evidence of a tracking sheet for all tips on suspected fraud/abuse.	
15.1.16.4.1	All tips (any program integrity case opened within the previous two (2) weeks) shall be	CYE 16 ABH of LA Corporate Compliance FWA Plan Final,	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	reported to DHH and MFCU:	Section X, page 15. 145 ABH 2016 Report		Compliance Fraud/ Waste/Abuse Plan. The MCO also provided evidence of a tracking sheet for all tips on suspected fraud/abuse.	
15.1.16.4.2	Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 145 ABH 2016 Report	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided evidence of a tracking sheet for all tips on suspected fraud/abuse.	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15.	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.1.16.4.4	All confirmed or suspected enrollee fraud and abuse shall immediately be reported to DHH and local law enforcement.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. MCO Fraud Referral Template	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided a template for referring suspected fraud/abuse to LDH.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. MCO Fraud Referral Template	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided a template for referring suspected fraud/abuse to LDH.	
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 related to Medicaid claims:	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 006 MCD Initial Case Opening & Actions by Investigator	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided the policy and procedure for opening an investigation as evidence of the processes the pan follows for investigating suspected fraud/abuse.	
15.1.16.7.1	Contact the subject of the investigation about any matters relating to the investigation;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final,	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate	

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		Section X, page 15.		Compliance Fraud/ Waste/Abuse Plan.	
15.1.16.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15.	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15.	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 145 ABH 2016 Reporting	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 15. 002 MCD SIU Overview Records Retention Destruction Policy	Full	The requirement is stated verbatim on page 15 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, pages 15-16. Terminated Provider Workflow	Full	The requirement is stated verbatim on pages 15-16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. Additionally, the MCO provided the Terminated Provider Workflow, outlining the process the MCO follows upon the termination of a provider.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, pages 15-16. Aetna Better Health of Louisiana Facility Service Agreement, Section 5.3.2,	Full	The requirement is stated verbatim on pages 15-16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	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 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.	page 12. Records Retention Destruction Policy			
15.1.19	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving nay amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16. Aetna Better Health of Louisiana Facility Service Agreement	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.1.23	The MCO shall have at least one (1) full-time investigator or 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 14. Medicaid SIU Team	Full	The requirement is stated verbatim on page 14 of the MCO's Corporate Compliance Fraud/Waste/ Abuse Plan. The MCO also provided a chart depicting the SIU team and the investigators for each state in which the plan operates.	
15.2	**Fraud and Abuse Compliance Program**				
15.2.1	In accordance with 42 CFR§438.608(a), the	CYE 16 ABH of LA Corporate	Full	The requirement is addressed on	

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	MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	Compliance FWA Plan Final, Section I, page 3. 002 MCD SIU Overview Update		page 3 of the MCO's Corporate Compliance Fraud/Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section II, pages 4-5 Compliance Committee Meeting Agenda & Minutes A-LA 3000.02 Compliance Manager Designation	Full	3000.02 describes the designation of a compliance officer and the responsibilities of that officer. Additionally, pages 4-6 of the Corporate Compliance Fraud/Waste/Abuse Plan describe the Compliance Director position, as well as the Program Integrity office and the Compliance Committee and the responsibilities of each.	
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 MCO 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:	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, pages 4-5.	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3.	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3.	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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 improvement activities, and provider	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3.	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	activities;				
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;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3.	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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);	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3. A-LA 3000.41 Compliance Review and Monitoring	Full	The requirement is stated verbatim on page 3 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided 3000.41, which outlines the MCO's processes and procedures for Compliance Review and Monitoring.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 3. A-LA 3000.12 Reporting Compliance Issues or Inquires	Full	The requirement is stated verbatim on pages 3-4 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided its policy for reporting compliance issues.	
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);	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 4. A-LA 3000.17 Corrective Action	Full	The requirement is stated verbatim on page 4 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided its policy for developing and implementing corrective action.	
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 4.	Full	The requirement is stated verbatim on page 4 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.2.3.9	Effective education for the Program Integrity Officer, program integrity investigators, managers, employees, providers, and members to ensure that they know and understand the provisions of MCO's compliance plan;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section I, page 4. A-LA 3000.20 Compliance Education and Training	Full	The requirement is stated verbatim on page 4 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.2.3.10	Fraud, Waste, and Abuse Training shall	CYE 16 ABH of LA Corporate	Full	On page 3 of 3000.20, it states that	

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	include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.	Compliance FWA Plan Final, Section V, page 8. Louisiana Fraud Training A-LA 3000.20 Compliance Training and Education		"All plan personnel will attend mandatory training and education courses…at least once per year." Additionally, the policy also states that the plan provides New Hire Compliance Training and that new employees must acknowledge that they have received this training. Neither the policy, nor the Corporate Compliance Fraud/Waste/Abuse Plan specify that the new hire training will occur within 30 days of hire. During the onsite interview, the MCO stated that new hire training does occur within 30 days of hire and provided an internal tracking sheet, which contains the hire dates and the date of completion of training for both new hires and for established employees. All training occurred within 30 days for all new hires.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section V, page 8. Business Code of Conduct, New Employee Training.	Full	Page 8 of the Corporate Compliance Fraud/ Waste/Abuse Plan gives a general statement on training and education for employees. Policy No. 3000.20, page 3 states that "All plan personnel will attend mandatory training and education courses… at least once per year." Additionally, the policy also states that the MCO provides New Hire Compliance Training and that new employees must acknowledge that they have received this training. During the onsite interview, the MCO stated that new hire training does occur within 30 days of hire and provided an internal tracking sheet, which contains the hire dates	

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	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.			and the date of completion of training for both new hires and for established employees. All training occurred within 30 days for all new hires.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16. Employee Screening Process, e-mail A-LA 3000.42 Excluded Individuals	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided 3000.42 as evidence of procedures taken to screen prospective and current employees, providers, and other affiliated entities against exclusion lists.	
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 my be determined by DHH	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16. OIG, DHH checks	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	prescribed by the excluded provider or individual. 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 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).				
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 16 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 16.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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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 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 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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);	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.5.2.2	Number of complaints reported to the Program Integrity Officer;	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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 case and any other information necessary to describe the activity regarding the complainant.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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15.5.2.4	The MCO, through its compliance officer, shall attest to DHH that a search of website referenced in Section 15.3.3 has been completed to capture all exclusions.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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:	Aetna Better Health of Louisiana Facility Services Agreement, Sections 4.5, 5.3.1.	Full	The requirement is addressed in the MCO's Compliance Addendum, Sections 4.5 and 4.6.	
15.6.1.1	Accurate and legible;	Aetna Better Health of Louisiana Facility Services Agreement, Section 5.3.1	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
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	Aetna Better Health of Louisiana Facility Services Agreement, Section 5.3.2	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	Aetna Better Health of Louisiana Facility Services Agreement, Section 5.3.2 and 5.4.	Full	Requirement is addressed in the plan's Compliance Addendum, Section 4.6.	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex, and legal guardianship (if applicable);	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name or service provider;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.1.1 and 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
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;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.5	Referrals including follow-up and outcome of	Aetna Better Health of	Full	The requirement is addressed in the	

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	referrals;	Louisiana Facility Services Agreement, Section 2.6		MCO's Compliance Addendum, Section 4.6.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.7	Signed and dated consent forms (as applicable);	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.8	Documentation of immunization status;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	R The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.9	Documentation of advance directives, as appropriate;	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of services; Chief complaint or 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.	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing, and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.6.	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.5	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.5.	
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 sic (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 agent	Aetna Better Health of Louisiana Facility Services Agreement, Section 4.7 and 5.3.1	Full	The requirement is addressed in the MCO's Compliance Addendum, Section 4.7 and 4.8.	

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	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.				
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.7.2	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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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 basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on page 17 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 17.	Full	The requirement is stated verbatim on pages 17-18 of the MCO's Corporate Compliance Fraud/	

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	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.			Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.7.8	DHH must notify the MCO of an identified 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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	from the Department or its agent.				
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
15.7.10	IN the event the provider does not refund overpayments identified by the Department r 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 or 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
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 for providers for which no MCO relationship existed.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18.	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
	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 12549 [42 CFR §438.610(a) and (b), 42 CFR §1002.1901(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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18. Louisiana Medicaid/CHIP Compliance Addendum, Section 2.2	Full	The requirement is addressed in Section 2.2 of the Compliance Addendum. Additionally, the requirement is addressed on pages 16 and 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section VII, page 10. Provider Exclusion Database Sweep Attestation	Full	Page 10 of the Corporate Compliance Fraud/ Waste/Abuse Plan addressed the fact that comprehensive criminal background checks are conducted on any potential employee and that potential employees are required to disclose any criminal convictions and/or exclusions from participation. The MCO also provided evidence of an email correspondence pertaining to the Attestation of Provider Exclusion Database Sweeps. However, neither document contained evidence of the fact that the plan provided LDH with criminal background checks or attestations thereof. During the onsite interview, however, the plan stated that LDH has yet to ask them for any criminal background checks or attestations of background checks. The MCO submits a monthly attestation letter confirming that background checks and exclusion checks were completed.	
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 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].	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section VII, page 10.	Full	The requirement is stated verbatim on page 10 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have	CYE 16 ABH of LA Corporate Compliance FWA Plan Final,	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate	

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	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.	Section X, page 18.		Compliance Fraud/ Waste/Abuse Plan.	
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-70 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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18. A-LA 3000.42 Excluded Individuals	Full	The requirement is stated verbatim on page 18 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. The MCO also provided 3000.42 as evidence of its process and procedures for handling excluded providers.	
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).	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 18. Louisiana Medicaid/CHIP Compliance Addendum, Section 3.11.	Full	The requirement is stated verbatim on pages 18-19 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. It is also addressed in the Compliance Addendum, Section 3.11.	
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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 19. Louisiana Medicaid/CHIP Compliance Addendum, Section 3.11.	Full	The requirement is stated verbatim on page 19 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan. It is also addressed in the Compliance Addendum, Section 3.11.	

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	Section 9/4/				
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, within thirty-five (35) days when any change in the MCO's management, ownership, or control occurs.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 19.	Full	The requirement is stated verbatim on page 19 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
18.2	**Information Related to Business Transactions-** 18.2.1 The MCO shall furnish to DHH and/or to the HSS, 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 exceeded $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 19.	Full	The requirement is stated verbatim on page 19 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
18.3	**Report of Transactions with Parties in Interest-** 18.3.1 The MCO shall report to DHH all	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 19.	Full	The requirement is stated verbatim on pages 19-20 of the MCO's Corporate Compliance Fraud/	

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	"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. 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.			Waste/Abuse Plan.	
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.	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 20.	Full	The requirement is stated verbatim on page 20 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to non-procurement 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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 20.	Full	The requirement is stated verbatim on page 20 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	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 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	CYE 16 ABH of LA Corporate Compliance FWA Plan Final, Section X, page 20.	Full	The requirement is stated verbatim on page 20 of the MCO's Corporate Compliance Fraud/ Waste/Abuse Plan.	

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	excluded individual; Any amount expended for which funds may not be 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 services unless the MCO provides the appropriate surety bond.				