Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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)]	Met This requirement is addressed in the Network Development Plan as well as in the Default Standards and Measures for Determining Appropriate Accessibility to Care P/P.	Network Development Plan Default Standards and Measures for Determining Appropriate Accessibility to Care Provider Handbook Network Development Plan LA HO Geo Access 3Q14 capacity minutes LA GEO 3Q14 capacity miles Physician Access Single Case Agreement	Demonstrating Access to Services and Benefits Full Document Section 2.4-2.6 Full Document Full Document Full Document Full Document	Pages 8-10 All Pages Pages 9-11 All Pages All Pages All Pages All Pages
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.	Met This requirement is addressed on page 15 of the Network Development Plan.	Network Development Plan Default Standards and Measures for Determining Appropriate Accessibility to Care Provider Handbook LA HO Geo Access 3Q14 capacity minutes LA GEO 3Q14 capacity miles Physician Access	General Provider Network Requirements Full Document Section 2.4-2.6 Full Document Full Document Full Document	Page 15 All Pages Pages 9-11 All Pages All Pages All Pages
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.	Not Met The contractual requirements are addressed in the Provider Handbook at pages 9-11 as well as in the Network Development Plan. Appointment availability data was submitted for Quarter 3 of 2014. Deficiencies in appointment availability were noted. The plan did not submit a CAP for these deficiencies.	Provider Handbook Default Standards and Measures for Determining Appropriate Accessibility to Care Network Development Plan LA HO Geo Access 3Q14 capacity minutes	Section 2.4-2.6 Full Document -Monitoring Member Access and Provider Availability -Demonstrating Access to Services and Benefits Full Document	Pages 9-11 All Pages Page 15 Pages 8-10 Page 8-10

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Health Plan failed to submit evidence of a CAP for the deficiencies noted above.	LA GEO 3Q14 capacity miles Amerigroup Louisiana Quarter 3 2014	Full Document Full Document	All Pages All Pages
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)].	Met This requirement is addressed in the Network Development Plan at page 3. The plan also submitted the Single Case Agreement Process and the Default Standards and Measures for Determining Appropriate Accessibility to Care which support this requirement.	Network Development Plan Single Case Agreement Process Default Standards and Measures for Determining Appropriate Accessibility to Care	-Provider Network Development Plan -Accessibility Detail -Covering Out-of-Network Full Document Full Document	Page 3 Page 9 Page 15 All Pages All Pages
7.1.5	The MCO's network providers shall comply with all requirements set forth in this RFP.	Met This requirement is addressed in the Network Development Plan at page 15. The plan communicates this requirement to the providers on page 5 of the Provider Manual.	Network Development Plan Provider Manual Hybrid Model Agreement Default Standards and Measures for Determining Appropriate Accessibility to Care	Complying with RFP Requirements You are responsible for… Full Document Full Document	Page 15 Page 5 All Pages All Pages
7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206(c)(2).	Met This requirement is addressed in the Network Development Plan at page 15. The plan communicates this requirement to the providers on pages 54 through 56 of the Provider Manual.	Hybrid Model Agreement Network Development Plan Provider Manual	Section 6.13 Delivering Services in a Culturally Competent Manner Section 3.7	Page 19 Page 15 Pages 54-56
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that	Met This requirement is addressed in the Provider Handbook at pages	LALA_CAID_Provider Handbook 102014	Section 2.6 Section 2.10	Pages 10-11 Pages 12

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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:	10-11.	 GEO 3Q2014 capacity miles GEO 3Q14 capacity minutes La Provider Orientation LA New Model Agreement HyBird Physician Access	Section 4.10-4.11 Full Document Full Document Slide deck Section 6.5 LA Exceptions	Page 73 All Pages All Pages Slide 15 Page 17 Pages 16-17
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Met This requirement is addressed in the Provider Handbook at pages 10-11. In addition to the Provider Manual, the providers are made aware of this requirement in the plan's Provider Orientation training materials on slide 15.	LALA_CAID_Provider Handbook 102014 GEO 3Q2014 capacity miles GEO 3Q14 capacity minutes La Provider Orientation LA New Model Agreement HyBird Physician Access LA Member Handbook	Section 2.6 Section 2.10 Section 4.10-4.11 Full Document Full Document Slide deck Section 6.5 LA Exceptions Wait Time for Appointments	Pages 10-11 Pages 12 Page 73 All Pages All Pages Slide 15 Page 17 Pages 16-17 Page 11
7.2.1.2	Urgent Care within twenty-four (24) hours; Provisions must be available for obtaining urgent 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.	Met This requirement is addressed in the Provider Handbook at pages 9 through 11. In addition to the Provider Manual, the providers are made aware of this requirement in the plan's Provider Orientation training materials on slide 15.	LALA_CAID_Provider Handbook 102014 GEO 3Q2014 capacity miles GEO 3Q14 capacity minutes La Provider Orientation	Section 2.6 Section 2.10 Section 4.10-4.11 Full Document Full Document Slide deck	Pages 10-11 Pages 12 Page 73 All Pages All Pages Slide 15

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
			LA New Model Agreement HyBird	Section 6.5	Page 17
			Physician Access	LA Exceptions	Pages 16-17
			LA Member Handbook	Wait Times for Appointment	Page 11
7.2.1.3	Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Met This requirement is addressed in the Provider Handbook at pages 9 through 11. In addition to the Provider Manual, the providers are made aware of this requirement in the plan's Provider Orientation training materials on slide 15.	LALA_CAID_Provider Handbook 102014	Section 2.6 Section 2.10 Section 4.10-4.11	Pages 10-11 Pages 12 Page 73
			GEO 3Q2014 capacity miles	Full Document	All Pages
			GEO 3Q14 capacity minutes	Full Document	All Pages
			La Provider Orientation	Slide deck	Slide 15
			LA New Model Agreement HyBird	Section 6.5	Page 17
			Physician Access	LA Exceptions	Pages 16-17
			LA Member Handbook	Wait Times for Appointment	Page 11
7.2.1.4	Routine, non-urgent, or preventative care visits within six (6) weeks;	Met This requirement is addressed in the Provider Handbook at pages 9 through 11. In addition to the Provider Manual, the providers are made aware of this requirement in the plan's Provider Orientation training materials on slide 15.	LALA_CAID_Provider Handbook 102014	Section 2.6 Section 2.10 Section 4.10-4.11	Pages 10-11 Pages 12 Page 73
			GEO 3Q2014 capacity miles	Full Document	All Pages
			GEO 3Q14 capacity minutes	Full Document	All Pages
			La Provider Orientation	Slide deck	Slide 15
			LA New Model Agreement HyBird	Section 6.5	Page 17
			Physician Access	LA Exceptions	Pages 16-17
			LA Member Handbook	Wait Times for Appointment	Page 11

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	Met This requirement is addressed on page 12 of the Provider Handbook.	Provider Handbook LA Member Handbook	Section 2.10 Wait Times for Appointment	Page 12 Page 11
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and	Met This requirement is addressed on page 12 of the Provider Handbook.	Provider Handbook LA Member Handbook	Section 2.10 Wait Times for Appointment	Page 12 Page 11
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 apply for existing ember 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 fourteen (14) days; within the second trimester within seven (7) days; within their third trimester within three (3) days; high risk pregnancies within three (3) days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	Met This requirement is addressed on page 10 of the Provider Handbook. This requirement is also addressed in the New Model Agreement with providers at section 6.27.	Provider Handbook New Model Agreement Hybrid LA Member Handbook	Section 2.6 Section 6.27 Wait Times for Appointment	Page 10 Page 21 Page 11
7.2.1.8	Follow-up visits to ED visits in accordance with ED attending provider discharge instructions.	Met This requirement is addressed in the Provider Handbook under Discharge Planning at page 72.	LA Caid Provider Handbook La Handbook 2015	Discharge Planning 4.7 Waite Times for Appts	Page 72 Page 11
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 forty-five (45) minutes, including time in the waiting room and examining room: If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (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.	Met This requirement is addressed in the Provider Manual under section 2.6 on page 10.	Physician Access Provider Manual La Handbook 2015 LAPEC- Access and Availability LA Member Handbook	LA Exceptions Section 2.6 Wait times for appts. Full Document Wait Times for Appointment	Pages 16 and 17 Page 10 Page 12 All Pages Page 11

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P.	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages
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 (Appendix UU states 20 miles)	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report Deficiencies were found regarding member access to PCPs within the mileage requirements. Plan submitted gap analysis indicating current status as of 1/12/15 and on-going plans to address deficiency.	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages
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.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report Deficiencies were found regarding member access to Hospitals within the mileage requirements. Plan submitted gap analysis indicating current status as of 1/12/15	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		and on-going plans to address deficiency.			
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	**Specialists** • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT **– Network Providers by Specialty Type.** DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report Deficiencies were found regarding member access to the following specialties: **Endocrinology and Metabolism** **Infectious Disease** **Rheumatology** **Surgery – Colon and Rectal** **Surgery – Neurological** **Physical Therapy** **Occupational Therapy** Plan submitted gap analysis indicating current status as of 1/12/15 and on-going plans to address deficiency. .	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages
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.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report Deficiencies were found regarding member access to Lab and Radiology Services. Deficiencies were result an error in the combined Lab and X-Ray reporting. Plan explained error found in GeoAccess maps and have made corrections.	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages
7.3.5 7.3.5.1 7.3.5.2	**Pharmacies** • Travel distance shall not exceed 10 miles in urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	Not Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Deficiencies were found regarding member access to Pharmacies within the 10m requirement in urban parishes. The plan did not provide a gap analysis or a CAP to address these deficiencies. Plan states that their contract with ESI (PBM) addresses gaps and the plan monitors activities and GeoAccess reports. Submitted ESI Pharmacy contract. Review comment: This is not a gap analysis nor a CAP. Response does not provide required evidence.	HO GEO 3Q14 ESI Pharmacy Contract		
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.	Not Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility P/P. Geo Access Report Missing from the documentation was geo access reporting on hemodialysis centers. The plan did not provide a gap analysis or a CAP to address these deficiencies. Plan states: A full comparison of the Amerigroup Dialysis Network vs. that of the other Bayou Health Plans in July 2014, Amerigroup had the most comprehensive network, by far. Reviewer comment: A comparison to other Bayou Health Plans does not indicate compliance with this standard. Response does not provide required evidence.	Default Standards and Measures for Determining Appropriate Accessibility Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document Full Document	All Pages All Pages All Pages
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.	Not Met Deficiencies were observed in the geo access reporting thereby rendering that the network has an insufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Reviewer comment: The Plan acknowledged the continuing deficiencies of some providers and the Plan continues to monitor accessibility and looks	Geo Access 3Q14 HO GEO 3Q14	Full Document Full Document	All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		for opportunities to contract with new providers.			
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. 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.	Met This requirement is addressed in the Provider Handbook at section 2.2 on page 6 and also on pages 9 though 11.	LA-PM-0012-142015 Provider Handbook_CMAP Default Standards and measures for Accessibility to Care_ LA Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity Desktop Process After Hours Survey LA Appointment Availability Non Comp LA Appt Avail Survey Response	Section 2.2 Section 2.5 Section 2.6 Full Document Full Document Full Document Full Document Full Document	Page 6 Pages 9-10 Page 11 All Pages All Pages All Pages All Pages All Pages
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); 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).	Met This requirement is detailed in the Network Development Plan on pages 17 and 25. The requirement is communicate to the providers in their contract.	Network development Plan OPH amendment OPH contract LA New Model Agreement Hybrid	-Provider Participation -FQHC/RHC Clinic Services School Based Clinics Full Document Full Document Full Document	Page 17 Page 25 Page 25 All Pages All Pages All Pages
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.	Met This requirement is addressed on page 17 of the Network Development Plan under 'Reasonable and Good-faith Efforts'.	Network development plan LA New Model Agreement Hybird LA New Model Agreement PHY La New Model Agreement Ancillary	Reasonable and good faith efforts Entire document Entire document Entire document Entire document	Page 17 Entire document Entire document Entire document Entire document

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.6.1.3	If a current Medicaid provider requests participation in a 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.	Met This requirement is addressed on page 17 of the Network Development Plan under 'Reasonable and Good-faith Efforts'.	Network development plan LA New Model Agreement Hybird LA New Model Agreement PHY La New Model Agreement Ancillary	Reasonable and good faith efforts Entire document Entire document Entire document	Page 17 Entire document Entire document Entire document
7.6.1.4	The provision in Section (7.6.1.2 and 7.6.1.3) does not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Met This requirement is addressed on page 17 of the Network Development Plan under 'Limiting Participation'.	Network Development Plan	Limiting Participation	Page 17
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)].	Met This requirement is addressed on page 17 of the Network Development Plan under 'Limiting Participation'.	Network Development Plan	Limiting participation	Page 17
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 https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdbhipdb. hrsa.gov/index.jsp.	Met This requirement is addressed on page 17 of the Network Development Plan under 'Exclusion from Participation'. Additionally, the plan submitted their Cred/Recred P/P as well as the Excluded Individual and Entities – Prohibition on Hiring or Contracting P/P which further address the requirement.	Network Development Plan Credentialing and re-credentialing for Licensed Independent Practitioners Excluded Individuals and Entities – Prohibition or Hiring or Contracting Government Sanctions Notification and Ongoing Monitoring	Exclusion from Participation Section i) Section p)(ii) Full Document Full Document Full Document	Page 17 Page 7 Page 22 Full Document Full Document Full Document

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.6.3 7.6.3.1	**Other Enrollment and Disenrollment Requirements -** The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Met This requirement is addressed on page 17 of the Network Development Plan. This requirement is communicated to the providers in their contract, a sample of which was submitted by the plan.	Network Development Plant La New Model Agreement Hybrid	Other Enrollment and Disenrollment Requirements Section 6.11	Page 17 Page 19
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	Met This requirement is addressed in the Network Development Plan on page 18. The plan also submitted the Provider Handbook which addresses how the requirement is communicated to the providers (page 11) as well as the ADA compliance for Providers P/P.	Network Development Plan Provider Handbook Americans with Disabilities Act compliance for Providers	Americans with Disabilities Act 2.6 PCP Access and Availability Full document	Page 18 Page 11 All Pages
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.	Met This requirement is addressed on page 18 of the Network Development Plan under Terminating Provider Contracts and Notices to members. This requirement is communicated to the providers in their contract.	Network Development Plan La New Model Agreement Hybird	Termination Providers Contracts and Notice to Members	Page 18 Section 6.39 page 23
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).	Met This requirement is addressed on page 18 of the Network Development Plan under Terminating Provider Contracts and Notices to members. This requirement is communicated to the providers in their contract.	Network Development Plan Continuity of Care Core Process Provider terminations PCP Specialist and Hospital LA Member Handbook	Termination Provider Contracts and Notices to members Policy If Your Primary Provider's Office Moves, Closes or leaves the AGP Network	Page 18 Page 5-6 Page 3 Page 9
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.	Met This requirement is addressed in the Provider Handbook on page 10 and 11, section 2.6.	La Provider Handbook	Section 2.6	Page 10-11

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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:	Met This requirement is addressed on page 43 of the Provider Handbook under Medical Care.	La Provider Handbook LA Handbook New Model Agreement Ancillary New Model Agreement Physician New Model Agreement Facility New Model Agreement Hybrid	Medical Care Take part in making decisions about your health Section 6.6 Section 6.6 Section 6.6 Section 6.6	Page 43 Page 52 Pages 14-15 Pages 15-16 Page 15 Page 17
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Met This requirement is addressed in the Provider Handbook at pages 10 and 11. Additionally, the New Model Agreement supports this requirement.	LA-PM-0012-142015 Provider Handbook_CMAP New Model Agreement Ancillary New Model Agreement Physician New Model Agreement Facility New Model Agreement Hybrid	2.6 PCP Access and Availability Section 6.6 Section 6.6 Section 6.6 Section 6.6	Page 11 Pages 14-15 Pages 15-16 Page 15 Page 17
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.	Met This requirement is addressed in the Provider Handbook at pages 10 and 11.	LA-PM-0012-142015 Provider Handbook_CMAP	2.6 PCP Access and Availability	Page 11
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.	Met This requirement is addressed in the Provider Handbook at pages 10 and 11.	LA-PM-0012-142015 Provider Handbook_CMAP	2.6 PCP Access and Availability	Page 11
7.8	**Primary Care**				
7.8.0	The PCP shall serve as the member's initial and most important point of interaction with the MCO's provider network. A PCP in the MCO must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.	Met This requirement is addressed in the Provider Handbook at pages 7 through 11.	LA Provider Handbook –CMAP	Handbook	Pages 7-11
7.8.1	**Assignment of Primary Care Providers**				
7.8.1.1	As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of MCO.				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.8.1.2	If the choice of MCO and PCP is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of MCO and if available the PCP of choice.				
7.8.1.3	The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a MCO.				
7.8.1.4	The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to MCO.	Met This requirement is addressed on page 2 of the Primary Care Provider Selection Assignment and Change Request P/P at Section 1b3.	Primary Care Provider Selection Assignment and Change Requests - LA	Section 1)b)3)	Page 2
7.8.1.5	The MCO shall confirm the PCP selection information in a written notice to the member.	Met This requirement is addressed on page 4 of the Primary Care Provider Selection Assignment and Change Request P/P.	Primary Care Provider Selection Assignment and Change Requests - LA	# 1)d)	Page 3
7.8.1.6	If no PCP is selected on the Member File received from the Enrollment Broker, the MCO shall contact the member, as part of the welcome call, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP or auto assign a PCP;	Met This requirement is addressed on page 19 of the Network Development Plan.	Network Development Plan LA Member Handbook	Assignment of PCP LA Exceptions	Page 19 Page 6
7.8.1.7	Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members, as appropriate.	Met This requirement is addressed on page 19 of the Network Development Plan.	Network Development Plan LA Member Handbook	Assignment of PCP Picking a PCP	Page 19 Page 7
7.8.1.8	Members, for whom an MCO is the primary payor, who do not proactively choose a PCP will be auto-assigned to a PCP by the MCO. Members, for whom an MCO is a secondary payor, will not be assigned to a PCP by the MCO, unless the members request that the MCO do so.	Met This requirement is addressed on page 19 of the Network Development Plan.	Network Development Plan Primary Care Provider Selection and Assignment and Change Request	Assignment of PCP Procedures	Page 19 Page 1 and 2
7.8.1.9	The MCO shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.	Met The Monitoring Primary Care and Physician document was not in the Provider Network folder. This requirement is addressed on page 4 of the Primary Care Provider Selection Assignment and Change Request	Monitoring Primary Care and Physician Extendors Primary Care Provider Selection Assignment and Change Request	Procedures Full document	Page 6 All Pages
7.8.1.10	If the member does not select a PCP and is auto assigned to a PCP by the MCO, the MCO shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.	Met The plan places no prohibitions on the amount of times a member may change their PCP. See Primary Care Provider Selection Assignment and Change Request Section 2.	Primary Care Provider Selection Assignment and Change Request	Procedure	Item # 2

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.8.1.11	Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12) months beginning from the original date the member was assigned to the MCO.	Met The plan places no prohibitions on the amount of times a member may change their PCP. See Primary Care Provider Selection Assignment and Change Request Section 2.	Primary Care Provider Selection Assignment and Change request	Procedure	Item #2
7.8.1.12	If a member requests to change his or her PCP with cause, at any time during the enrollment period, the MCO must agree to grant the request.	Met The plan places no prohibitions on the amount of times a member may change their PCP. See Primary Care Provider Selection Assignment and Change Request Section 2. The Network Development Plan also addresses this requirement. The requirement is communicated to the members in the Member Handbook on page 9.	Network Development Plan LA Member Handbook	Assignment of PCP How to change your PCP	Page 19 Page 9
7.8.1.13	The MCO shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The MCO shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP.	Met This requirement is addressed on page 3 on the Provider Terminations – Primary Care Provider Specialist and Hospital P/P as well as on pages 1 through 4 of the Primary Care Provider Selection Assignment and Change Request P/P.	Provider Terminations – Primary Care Provider Specialist and Hospital Primary Care Provider Selection Assignment and Change Request	La Exceptions Procedure	Page 3 Pages 1-4
7.8.1.14	The MCO shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the MCO signs the Contract with DHH.	Met This requirement is addressed on page 21 of Continuity of Care – Core Process and Emergency Services Core Process; page 15	All 30-day deliverables are submitted by Regulatory Manager in accordance with the requirements of the contract		
7.8.1.15	The MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination.	Met This requirement is addressed on page 3 of Provider Terminations Primary care Specialist and Hospital P/P.	Provider Terminations Primary care Specialist and Hospital	Procedure	Page 3
7.8.1.16	The MCO shall have written policies and procedures for handling the assignment of its members to a PCP. The MCO is responsible for linking to a PCP all assigned MCO members for whom the MCO is the primary payor.	Met This requirement is addressed on pages 1 through 4 of the Primary Care Provider Selection Assignment and Change Request P/P.	Primary Care Provider Selection Assignment and Change Request	Procedure	Page 1-4
7.8.1.17	**PCP Auto-Assignments**				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.8.1.17.1	The MCO is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign to a PCP an enrollee for whom the MCO is the primary payor when the enrollee:	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P.	Primary Care Provider Selection Assignment and Change Request	Full document	All Pages
7.8.1.17.2	Does not make a PCP selection after a voluntary selection of a MCO; or	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Request	LA Exceptions	Page 4
7.8.1.17.3	Selects a PCP within the MCO that has reached their maximum physician/patient ratio; or	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Request	LA Exceptions	Page 4
7.8.1.17.4	Selects a PCP within the MCO that has restrictions/limitations (e.g. pediatric only practice).	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Requests	LA Exceptions	Page 4
7.8.1.17.5	Does not make a selection of a PCP for a newborn within fourteen (14) calendar days of birth. The effective date of a PCP selection or assignment of a newborn will be no later than the first month of enrollment subsequent to the birth of the child.	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Requests	LA Exceptions	Page 4
7.8.1.17.6	Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the MCO plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Requests	LA Exceptions	Page 4
7.8.1.17.7	If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.	Met This requirement is addressed in the Primary Care Provider Selection Assignment and Change Request P/P on page 4.	Primary Care Provider Selection Assignment and Change Requests	LA Exceptions	Page 4
7.8.1.17.8	The final MCO and PCP automatic assignment methodology must be provided thirty (30) days from the date the MCO signs the contract with DHH. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the MCO's website, Provider Handbook, and Member Handbook.	Met This requirement is addressed on pages 13 and 14 of the Provider Handbook as well as in the Member Handbook at pages 7 through 9.	LA-PM-0012-142015 Provider Handbook_CMAP LA Member Handbook *The Member and Provider Handbooks are available online and this information can be accessed via these documents.	PCP Automatic Assignment Process for Members Picking a Primary Care Provider	Page 13 and 14 Page 7-9
7.8.2	**Primary Care Provider Responsibilities**				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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 the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;	Met This requirement is addressed in the Provider Handbook on pages 13 and 14.	LA-PM-0012-142015 Provider Handbook_CMAP LA Geo 3Q14 Capacity LA HO Geo 3Q14 Network Development Plan	Section 2.12 Full Document Full Document Provider Responsibilities	Page 13-14 All Pages All Pages Pages 19-21
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;	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients.	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21
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;	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21
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;	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21
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.	Met This requirement is addressed in the Provider Handbook on pages 8.	LA-PM-0012-142015 Provider Handbook_CMAP Network Development Plan	Section 2.12 Section 2.2-2.3 Provider Responsibilities	Page 8 Pages 6-7 Pages 19-21

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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.	Met This requirement is addressed in the Provider Handbook on pages 7.	LA-PM-0012-142015 Provider Handbook_CMAP LAPEC Access and Availability Requirements Physician Access	Section 2..2 Full Document	Page 7 All Pages
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Met This requirement is addressed within the New Model Agreement Contract for physicians on page 13 section 5.3.	New Model Agreement Physician	Section 5.3	Page 13
7.8.3	**Specialty Providers**				
7.8.3.1	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).	Met This requirement is addressed in the Network Development Plan on pages 21 and 22.	Network Development Plan LA Geo 3Q14 capacity LA HO Geo 3Q14	Specialty Providers Full Document Full Document	Page 21-22 All Pages All Pages
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,	Met This requirement is addressed in the Network Development Plan on pages 21 and 22.	Network Development Plan LA Geo 3Q14 capacity LA HO Geo 3Q14	Specialty Providers Full Document Full Document	Page 21-22 All Pages All Pages
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	Not Met This requirement is addressed in the Network Development Plan; page 22. The plan had deficiencies in their geo access reports as well as in their appointment availability data. These deficiencies need to be addressed with a CAP or an analysis. A CAP or an analysis was not submitted so the standard remains Not Met	LA Geo 3Q14 capacity LA HO Geo 3Q14	Full Document Full Document	All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in Appendix TT with the ratio, distance, and appointment time requirements set in this Section and in Appendices SS and UU.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility to Care P/P.	Default Standards and Measures for Determining Appropriate Accessibility to Care LA Geo 3Q14 capacity LA HO Geo 3Q14 LA Provider Orientation	Full document Full document Full document Slide deck	All Pages All Pages All Pages Slides 14 and 15
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.	Met This requirement is addressed in the Network Development Plan; page 22	LA Geo 3Q14 capacity LA HO Geo 3Q14 LA Provider Orientation	Full document Full document Full document Slide deck	All Pages All Pages All Pages Slides 14 and 15
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.	Met This requirement is addressed in the Network Development Plan on page 22.	Network Development Plan	Direct Access to Specialists	Page 22
7.8.4	**Hospitals**				
7.8.4.1	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 hospital: 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.	Met This requirement is addressed in the Network Development Plan on page 22.	Network Development Plan LA Geo 3Q14 capacity	Hospitals Full document	Page 22 All Pages
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	Met This requirement is addressed in the Network Development Plan on page 10	LA Geo 3Q14 capacity	Full document	All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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.	Met This requirement is addressed in the Network Development Plan on page 10	LA Geo 3Q14 capacity	Full document	All Pages
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.	Met This requirement is addressed in the Network Development Plan on pages 22 and 23.	Network Development Plan LA Geo 3Q14 LA HO Geo 3Q14	Tertiary Care Full Document Full Document	Page 22-23 All Pages All Pages
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.	Met This requirement is addressed in the Network Development Plan on page 23.	Network Development Plan Provider Handbook	Direct Access to WH Care Women's Health Services – Prenatal Services	Page 23 Page 33
7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. 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;	Met This requirement is addressed in the Network Development Plan on page 23. The plan also addresses this requirement in the Provider Handbook at pages 25, 64 and 68.	LA Member Handbook Provider Handbook Network Development Plan	Family Planning Services Prior Auths Family Planning Family Planning/STD Care Out of Area / Out of Network Direct Access to WH Care	Page 17 Page 28 Page 25 Page 64 Page 68 Page 23
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	Met This requirement is addressed in the Network Development Plan on page 23. The plan also addresses this requirement in the Provider Handbook at pages 25, 64 and 68.	LA Member Handbook Provider Handbook Network Development Plan	Family Planning Services Prior Auths Family Planning Family Planning/STD Care Out of Area / Out of Network Direct Access to WH Care	Page 17 Page 28 Page 25 Page 64 Page 68 Page 23

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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;				
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.	Met This requirement is addressed in the Provider Handbook at page 7.	Provider Handbook	Maintain Medical Records	Page 7
7.8.7 7.8.7.1	**Prenatal Care Services -** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	Met This requirement is addressed in the Perinatal Services Policy.	Perinatal Services Policy Primary Care Provider Selection, Assignment, and Change Requests = LA	Full Document LA Exceptions	All Pages Page 4
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.	Met This requirement is addressed in the Network Development Plan on page 24.	Network Development Plan LA Geo 3Q14 capacity Miles Louisiana Medicaid Provider Directory	Other Service Providers Full Document Full Document	Page 24 All Pages All Pages
7.8.9	**Non-Emergency Medical Transportation**				
7.8.9.1	The MCO is responsible for **all** necessary Non-Emergency Medical Transportation for its members. This includes transportation to both services covered within the scope of this RFP and all state plan services currently excluded, such as, but not limited to dental and behavioral health.	Met This requirement is addressed in the Emergency Services Policy.	Emergency Services Policy	Policy Statement Exceptions: Louisiana	Page 1 of 17 Page 12 of 17 & Page 13 of 17 & page 15 of 17
7.8.9.2	For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall require its transportation contractor to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.	Met This requirement is addressed in the Member Services Functions documentation at page 6.	Member Services Functions	LA Exceptions	Page 6

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.8.9.3	If a member requests an MCO provider who is located beyond access standards, and the MCO has an appropriate provider within the MCO who accepts new patients, it shall not be considered a violation of the access requirements for the MCO to grant the member's request. However, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this selected provider, and the MCO shall notify the member in writing as to whether or not the MCO will provide transportation to seek care from the requested provider.	Met This requirement is addressed in the Default Standards and Measures for Determining Appropriate Accessibility to Care P/P on page 4.	Default Standards and Measures for Determining Appropriate Accessibility to Care	LA Exceptions	Page 4
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.	Met This requirement is addressed in the Network Development Plan at page 17. A sample of the contract was provided by the plan.	Sample ECM Hybrid Contract Network Development Plan Louisiana Medicaid Provider Directory LA Geo 3Q14 capacity miles	Section 6.33 Provider Participation FQHC/RHC Clinic Services Full document Full Document	Page 20 . Page 17 Page 25 All pages All Pages
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	Met This requirement is addressed in the Network Development Plan on pages 17 and 25 (outreach discussed on 25).	Network development plan Louisiana Medicaid Provider Directory La Geo 3Q14 capacity miles	Provider Participation School Based Health Clinics Full Document Full Document	Page 17 Page 25 All Pages All Pages
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).	Met This requirement is addressed in the Network Development Plan on page 17.	Network development plan OPH contract OHP amendment Louisiana Medicaid Provider Directory. LA Geo 3Q14 capacity miles	Provider Participation Full Document Full Document Full Document Full Document	Page 17 All Pages All Pages All Pages All Pages
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	Met This requirement is addressed in the Network Development Plan on page 17.	Network development plan OPH contract OHP amendment Louisiana Medicaid Provider Directory.	Provider Participation Full Document Full Document Full Document	Page 17 All Pages All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.		LA Geo 3Q14 capacity miles	Full Document	All Pages
7.9	**Network Provider Development Management Plan**				
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will 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):	Met This requirement is addressed in the Network Development Plan.	Network Development Plan	Full Document	All Pages
7.9.1.1	Anticipated maximum number of Medicaid members;	Met This requirement is addressed in the Network Development Plan on page 4.	Network Development Plan		Page 4
7.891.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Met This requirement is addressed in the Network Development Plan on page 4.	Network Development Plan		Page 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;	Met This requirement is addressed in the Network Development Plan on page 5.	Network Development Plan		Page 5
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Met This requirement is addressed in the Network Development Plan.	Network Development Plan Directory Monitoring PCP Provider PCP Capacity	# MCO Providers Full Document # j	Page 6 All Pages Page 3

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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.	Met This requirement is addressed in the Network Development Plan on page 8.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles American with disabilities Act	 Full Document Full Document Full Document	Page 8 All Pages All pages All Pages
7.9.2	The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.1	Assurance of Adequate Capacity and Services	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.2	Access to Primary Care Providers	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.3	Access to Specialists	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity	Demonstrating Access to Services and Benefits Full Document	Pages 8 – 11 All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
			LA Geo HO access 3Q14 miles	Full Document	All Pages
7.9.2.4	Access to Hospitals	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.5	Timely Access	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.6	Service Area	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages
7.9.2.7	Other Access Requirements: Direct Access to Women's Health , Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	Met This requirement is addressed in the Network Development Plan on pages 8 through 11.	Network Development Plan LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	Demonstrating Access to Services and Benefits Full Document Full Document	Pages 8 – 11 All Pages All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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.	Met This requirement is addressed in the Network Development Plan on page 11.	Network Development Plan	Identify and Addressing Gaps in Network	Page 11
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.	Met This requirement is addressed in the Network Development Plan. The plan provided geo access reports and mapping for all network providers and each provider type demonstrating network capacity.	Network Development LA GEO access 3Q14 capacity LA Geo HO access 3Q14 miles	GEO Mapping and Coding the Network	Page 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;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
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;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
7.9.5.3	Evaluate the quality of services delivered by the network;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
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	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
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;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
7.9.5.7	Provide training for its providers and maintain records of such training;	Met This requirement is addressed in the Network Development Plan on pages 13 and 14.	Network Development Plan	P&Ps	Page 13-14
7.9.5.8	Track and trend provider inquiries/complaints/requests for	Met	Network Development Plan		Page 14

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	information and take systemic action as necessary and appropriate;	This requirement is addressed in the Network Development Plan on page 14.			
7.9.5.9	Ensure that provider calls 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.	Met This requirement is addressed in the Network Development Plan on page 14.	Network Development Plan		Page 14
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.	Met This requirement is addressed in the Network Development Plan on pages 14 and 15.	Network Development Plan	Evaluation	Page 14-15
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	Met This requirement is addressed in the Network Development Plan on page 15.	Network Development Plan	Approval by DHH	Page 15
7.10	**Patient-Centered Medical Home (PCMH)**				
7.10.1 7.10.2 7.10.3	Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The MCO shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	Full document	All Pages
7.10.4	The MCO shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date that identifies the methodology for promoting practice transformation to providing PCMHs for its members. The Plan shall include, but not be limited to the following:	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	Full document	All Pages
7.10.4.1	Any payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain a medical home practice:	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	N/A	Page 2
7.10.4.2	Provision of technical support, to assist in their transformation;	Met	PCMH Implementation Plan	N/A	Page 3

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		This requirement is addressed in the PCMH Implementation Plan.			
7.1o.4.3	Facilitation of specialty provider network access and coordination to support the PCMH;	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	N/A	Page 4
7.10.4.4	Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as, the coordination of services with specialty behavioral health providers and other community support services;	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	N/A	Page 4
7.10.4.5	Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan	N/A	Page 5
7.10.4.6	Methodology for evaluating the level of practice participation, level of practice transformation and any capacity and/or health outcomes achieved, The findings from all evaluations shall be included in the annual update of the PCMH Implementation Plan.	Met This requirement is addressed in the PCMH Implementation Plan.	PCMH Implementation Plan		Page 4
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; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Met This requirement is addressed in the Network Development Plan on page 31.	Network Development Plan Marketing Plan	Coordination Cooperate and Communicate With Other Agencies Section 5.4.8 and 5.4.9	Page 31 Page 21 Page 9
7.13	**Subcontract Requirements**				
7.13.1	In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.	Met This requirement is addressed in the Network Development Plan on page 31.	Network Development Plan	Subcontract Requirements	Page 31
7.13.2	The MCO shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.	Met This requirement is addressed in the Credentialing and Recredentialing for Licensed Independent Practitioners P/P.	Credentialing and Recredentialing for Licensed independent Practitioners	Full Document	All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.2.1	Within 30 days of the MCO signing the contract, it shall provide DHH with written provider credentialing and re-credentialling policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws	Met This requirement is addressed in the Credentialing and Recredentialing for Licensed Independent Practitioners P/P.	Credentialing and Recredentialing for Licensed independent Practitioners	Full Document	All Pages
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.	Met This requirement is addressed in the Credentialing and Recredentialing for Licensed Independent Practitioners P/P.	Credentialing and Recredentialing for Licenses Independent Practictioners La New Model Ageeement (Phy-AHP)	Full Document Section 6.11	All Pages Page 17
7.13.3	As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the MCO shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Network Development Plan	LA Exceptions Subcontractor Oversight	Pages 7-8 Page 32
7.13.3.1	All provider subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Utilization Management – Medicaid Delegation and Oversight Policy	LA Exceptions Full Document	Pages 7-8 All Pages
7.13.3.2	DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Utilization Management – Medicaid Delegation and Oversight Policy	LA Exceptions Full Document	Pages 7-8 All Pages
7.13.3.3	The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated;	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Utilization Management – Medicaid Delegation and Oversight Policy	LA Exceptions Full Document	Pages 7-8 All Pages Page 3
7.13.3.4	The MCO must have a written agreement between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;	Met The plan submitted the contracts they have with their subcontractors. The contracts specify the activities and reporting responsibilities delegated to the subcontractor and provides for revoking or imposing sanctions if the subcontractor's performance is inadequate.	Block Vision LA MSA Block Vision LA Base Agreement Univita LA Base Agreement LogistiCare Base Agreement	Full documents	All Pages
7.13.3.5	The MCO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Utilization Management – Medicaid Delegation and Oversight Policy	LA Exception Full Document	Pages 7-8 All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.3.6	The MCO shall identify deficiencies or areas for improvement, and take corrective action; and	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program.	Vendor Selection and Oversight Program Utilization Management – Medicaid Delegation and Oversight Policy	LA Exceptions Full Document	Pages 7-8 All Pages
7.13.3.7	The MCO shall specifically deny payments to subcontractors for Provider Preventable Conditions.	Met This requirement is addressed on pages 7 and 8 of the Vendor Selection and Oversight Program. In addition, Delegate Terminations and De-Delegation P/P addresses this requirement.	Vendor Selection and Oversight Program Delegate Terminations and de-delegation	LA Exceptions	Pages 7-8 Page 7
7.13.4	The MCO shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Met The plan submitted evidence that it submitted its vendor subcontracts to DHH prior to contracting for review and approval.	E-mail approval for Block contract E-mail approval for ESI contract E-mail approval for LogistiCare contract *Univita approval was obtained prior to current Regulatory Manager employment.	All Documents	All Pages
7.13.5	Notification of amendments or changes to any provider subcontract which, in accordance with Section 7.6 of this RFP, materially affects this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with Section 23.1 of this RFP.	Met This requirement is addressed in the New Model Agreement in section 6.38 on page 22.	New Model Agreement Physician	Section 6.38	Page 22
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5)or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	Met This requirement is addressed in the Credentialing and Recredentialing for Licensed Independent Practitioners P/P.	Credentialing and Recredentialing for Licensed Independent Providers New Model Agreement Physician Network Development Plan	Full Document Section 3.2 Section 5.5 Section b) Exclusion from participation	Page 16 Page 6 Page 13 Page 33 Page 17

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.7	The MCO shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the MCO's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the MCO shall provide immediate written notice to the provider.	Met This requirement is addressed on page 4 of the Provider Terminations – PCP, Specialist and Hospital P/P.	New Model Agreement Physician	Section 6.39	Page 22
7.13.8	If termination is related to network access, the MCO shall include in the notification to DHH their plans to notify MCO members of such change and strategy to ensure timely access to MCO members through out-of-network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.	Met This requirement is addressed in the Network Development Plan on page 18.	Network Development Plan	Terminating Provider Contracts and Notices to members	Page 18
7.13.9	The MCO shall make a good faith effort to give written notice of termination of a subcontract 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).	Met This requirement is addressed in the Network Development Plan on page 18.	Network Development Plan	Terminating Provider Contracts and Notices to members	Page 18
7.13.10	All subcontracts executed by the MCO pursuant to this Section shall, at a minimum, include the terms and conditions listed in Section25 of this RFP. No other terms or conditions agreed to by the MCO and its subcontractor shall negate or supersede the requirements in Section 25.	Met The plan submitted samples of their contracts which include the terms of the requirement. In additional, the contracts include a provision that renders null and void any requirement that is in conflict with the requirements of Medicaid.	New Model Agreement Ancillary New Model Agreement Physician New Model Agreement Facility New Model Agreement Hybrid In addition, contracts include a provision that renders null and void any requirement that is in conflict with requirements of Medicaid.	Full Documents	All Pages
7.14	**Provider-Member Communication Anti-Gag Clause**				
7.14.1	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:	Met The requirement language is contained within the Contractual Agreement on page 16 through 18. Suggestion: the plan should add this requirement to the Provider Manual.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17
7.14.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Met The requirement language is contained within the Contractual Agreement on page 16 through 18.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Suggestion: the plan should add this requirement to the Provider Manual.			
7.14.1.2	Any information the member needs in order to decide among relevant treatment options;	Met The requirement language is contained within the Contractual Agreement on page 16 through 18. Suggestion: the plan should add this requirement to the Provider Manual.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17
7.14.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Met The requirement language is contained within the Contractual Agreement on page 16 through 18. Suggestion: the plan should add this requirement to the Provider Manual.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17
7.14.1.4	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.	Met The requirement language is contained within the Contractual Agreement on page 16 through 18. Suggestion: the plan should add this requirement to the Provider Manual.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17
7.14.1.5	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.				
7.14.1.6	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.	Met The requirement language is contained within the Contractual Agreement on page 16 through 18. Suggestion: the plan should add this requirement to the Provider Manual.	LA New Model Agreement Hybird	Section 3.4 Section b)	Page 7 Page 16-17
7.15	**Pharmacy Network, Access Standards and Reimbursement**				
7.15.1	**Pharmacy Network Requirements**				
7.15.1.1	The MCO shall provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.	Not Met The documentation provided does not address the requirement. The plan should add the contractual requirement language to a P/P. LA Medicaid Addendum to Participating Provider Agreement was resubmitted and referenced page 1, Licensure as evidence of compliance. This submittal did not comply by adding language to a P/P.	LA Medicaid Addendum to Participating Provider Agreement	Full Document	All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.15.1.2	No MCO may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.	Not Met The documentation provided does not address the requirement. The plan should add the contractual requirement language to a P/P. LA Medicaid Addendum to Participating Provider Agreement was resubmitted and referenced page 4, Non-Payment Status or Exclusion from Federal Programs as evidence of compliance. This submittal did not comply by adding language to a P/P.	LA Medicaid Addendum to Participating Provider Agreement	Full Document	All Pages
7.15.1.3	The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies: • Names, locations and telephone numbers. • Any non-English languages spoken. • Identification of hours of operation, including identification of providers that are open 24-hours per day. • Identification of pharmacies that provide vaccine services. • Identification of pharmacies that provide delivery services.	Not Met Missing from the documentation is evidence of a P/P that states the requirement. The plan provided a template of the pharmacy directory; however no reference to the website was made. Find-a-doctor-pharmacy screen shot submitted that shows a link to find a pharmacy via Express Scripts search. A P/P was not submitted.	LA Pharmacy Directory Template	Full Document	All Pages
7.15.1.4	The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.	Not Met The document provided did not meet the requirement. The plan should cite documentation regarding the timeframe for updating the hardcopy and online versions of the directory. This requirement is addressed the LA Member Handbook; pages 3 & 38 by adding or pharmacy directory The LA Member Handbook did not provide evidence regarding the timeframe for updating the hardcopy and online versions of the directory.	ESI Network Provider Manual AGP Redacted Agreement	Full Document	All Pages
7.15.1.5	The MCO shall ensure PBM/PBA has a network audit program that includes, at a minimum: • Random audits to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. The MCO shall not utilize contingency-fee based pharmacy audits. • The MCO shall submit to DHH the policies of its audit program for approval.	Not Met The document provided did not address the requirement that the audit program include random audits to determine provider compliance with program policies. ESI Provider Manual, page 33; Quality Assurance Review states the PBM may audit claims but does not specifically reference random audits as indicated in standard and by previous reviewer.	Pharmacy Audit Overview	Full Document	All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Note: Email submitted verifying that ESI's policy that is addressed as Medicare also applies to LA Medicaid			
7.15.1.6	The MCO shall ensure that pharmacies submit the NPI of the prescriber on claims.	Met This requirement is addressed in the Prescriber NPI Requirements P/P.	A26 Prescriber NPI Requirements	Full Document	All Pages
7.15.1.7	The MCO must educate network providers about how to access their formulary and PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.	Met This requirement is addressed in the comprehensive Provider Orientation materials.	La Provider Orientation	Full Document	All Pages
7.15.1.10	Thirty days after enrollment of a new MCO into Bayou Health, DHH will require that the MCO and PBM receive active agreement from pharmacy providers to participate in the MCO's pharmacy network, even if the pharmacy provider has an existing relationship with the MCO's PBM. This means that if a pharmacy provider is already contracted with an MCO's PBM for other coverage products, notification alone will not be sufficient for that pharmacy provider to be considered part of the PBM's Medicaid network. The pharmacy provider must actively agree to the terms of the Medicaid contract addendum.	Not Met The document provided did not address the requirement. Evidence of active agreements should be provided. ESI Provider Agreement Template pages 1 & 2 indicates the contracted pharmacy provider is expected to provide services for its "Sponsors" but does not specifically refer to the agreement to service LA Medicaid nor is it an active agreement.	LA Medicaid Addendum to Participating Provider Agreement	Full Document	All Pages
7.15.3	**Specialty Drugs and Specialty Pharmacies**				
7.15.3.1	The MCO may limit distribution of specialty drugs from a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and is willing to accept the terms of the MCO's agreement.	Met The Integrated Accredo Specialty Pharmacy documentation addresses this requirement.	Integrated Accredo Client	Full Document	All Pages
7.15.3.2	A specialty drug is defined as one that is:	Met The Integrated Accredo Specialty Pharmacy documentation addresses this requirement.	Integrated Accredo Client	Full Document	All Pages
7.15.3.2.1	Not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or	Met The Integrated Accredo Specialty Pharmacy documentation addresses this requirement.	Integrated Accredo Client	Full Document	All Pages
7.15.3.2.2	Includes at least two of the following characteristics: • requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or • must be administered, infused or injected by a health care professional; or • the drug is indicated primarily for the treatment of: a	Met The Integrated Accredo Specialty Pharmacy documentation addresses this requirement.	Integrated Accredo Client	Full Document	All Pages

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or a rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or • the total monthly cost is $3,000 or more.				