Louisiana HealthCare Connections

2016 Compliance Audit

Review Period: September 2015 – August 2016

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Prepared on Behalf of
The State of Louisiana
Louisiana Department of Health

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Section 1: Introduction and Audit Overview

INTRODUCTION

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct Annual Compliance Audits every three years, followed by partial audits in the intervening years. The 2016 Annual Compliance Audit was a full audit of MCO compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

This report presents IPRO's findings of the 2016 Annual Compliance Audit for Louisiana Health Care Connections (LHCC).

AUDIT OVERVIEW

The purpose of the audit was to assess LHCC's compliance with federal and state regulations regarding access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The audit included a comprehensive evaluation of LHCC's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing/Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, care management, utilization management, provider credentialing, and communication between the MCO and member and provider communities.

Specifically, file review consisted of the following seven (7) areas:

1. Appeals
2. Behavioral Health Care Management
3. Case Management
4. Informal Reconsiderations
5. Member Grievances
6. Provider Credentialing/Recredentialing
7. Utilization Management Denials

Sample sizes for each file review type are presented in **Table 1**.

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Behavioral Health Care management	10
Case Management	10
Informal Reconsiderations	5
Member Grievances	10
Provider Credentialing	5
Provider Recredentialing	5
Utilization Management Denials	10

The period of review was September 1, 2015 through August 31, 2016. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," and "compliance not met" were used for each element under review. The definition of each of the review determinations is presented in **Table 2**.

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The MCO has met or exceeded the standard.
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

The 2016 Annual Compliance Audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared nine (9) review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in October 2016. The tools included the review elements drawn from the state and federal regulations. Upon reviewing the tools, LDH recommended elements to be added to the review tools to ensure completeness. Based upon the LDH's suggestions, the tools were revised, incorporating the elements added by LDH, and issued as final. These final tools were submitted to the MCO in October 2016 in advance of the onsite audit. All Medicaid MCOs in Louisiana were audited using the same review tools.

Once LDH approved the methodology, IPRO sent LHCC a packet that included the review tools along with a request for documentation and a guide to help MCO staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure FTP site.

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

Prior to the onsite visit, the MCO submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The MCO was given a period of approximately four weeks to submit documentation to IPRO. To further assist MCO staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs undergoing the audit, with LDH staff in attendance, approximately one week after the request packet was sent to the MCOs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline and answered any questions posed by MCO staff.

After the MCO submitted the required documentation, a team of three (3) experienced IPRO auditors was convened to review the MCO's policies, procedures and materials and assess their concordance with the state's contract

requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the onsite review discussion.

Onsite Visit

The onsite component of the audit was comprised of a two (2) day onsite visit, which included a review of elements in each of the nine (9) review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited LHCC on December 8-9, 2016 to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and for the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy was conducted in accordance to state standards.

Post-onsite Report Preparation

Following the onsite audit, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that the standard was met or a rationale for why the standard was not met and what evidence was lacking. For each element not fully compliant, IPRO provided a recommendation for the MCO to consider in order to attain full compliance.

Each draft report underwent a second level of review by IPRO staff not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval the draft reports were sent to the MCO with a request to furnish any additional documentation for all elements that were determined to be less than fully compliant. The MCO was given approximately two weeks to respond to the issues noted on the draft reports.

After receiving the MCO's response and any additional documentation, IPRO re-reviewed each element for which the MCO provided a response and missing documentation. As a result, several elements' review scores were either raised or converted to "Full Compliance" based on the additional documentation submitted and the reports were issued as final.

Section 2: MCO Summary of Findings

SUMMARY OF FINDINGS

Table 3 below provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	N/A	% Full
Core Benefits and Services	123	122	0	0	0	1	100%
Provider Network	163	157	6	0	0	0	96%
Utilization Management	92	90	1	0	0	1	99%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing/Member Education	77	75	0	0	0	2	100%
Member Grievances and Appeals	62	61	1	0	0	0	98%
Quality Management	86	85	0	0	0	1	100%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	105	0	0	0	0	100%
TOTAL	**722**	**709**	**8**	**0**	**0**	**5**	**99%**

As displayed in the above, 722 elements were reviewed and 8 were determined to be "substantially met," 5 were not applicable, while the remaining 709 were "fully met." None were determined to be "minimally met" or "not met." The overall compliance score was 99%.

It is IPRO's and the LDH's expectation that LHCC submit a corrective action plan for each of the 8 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that LHCC has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Five (5) of the 8 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to LHCC**.**

IPRO extracted from each of the nine detailed reports each element that the MCO was found to be less than fully compliant into a summary report to facilitate corrective action. This summary report includes each element reviewed, the final review determination, the MCO's initial response and suggestions to achieve full compliance.

Table 4: Deficient Audit Elements for LHCC

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
Provider Network					
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults Post Onsite Plan Response: Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co-occurring treatment shall not exceed 60 miles for 90% of adult members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults **Post Onsite Plan Response:** Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					Case Agreements if needed.
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults **Post Onsite Plan Response:** Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be consistent with provider registry data submitted to DHH by the	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Other Documents 4) Other Documents 5) Other Documents 6) Other Documents	Substantial	Quarterly Geo Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in place from the available documentation. Nonetheless, network adequacy gap analysis indicates continued gaps in a number of areas, examples of which are: Urban (Certain Regions) a) Hand Surgery: Goal: 75% of membership within 60 miles Actual: 46.4% of membership within 60 miles b) Pediatric Rheumatology: Goal: 75% of membership within 60 miles Actual: 42.8% of membership within 60 miles c) Lab/X ray: Goal: 100% of members within 10 miles Actual: 89.7% within 10 miles	As specified in our Quarterly Network Gap Analysis Urban: a) Hand Surgery - This is a very specific specialty and while we continually attempt to contract with new providers, there is a very limited number of Hand Surgeons in the state. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	plans as required in the MCO Systems Companion Guide. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.			Rural (Certain Regions) a) Pediatric Rheumatology: Goal: 100% of membership within 90 miles Actual: 59.8% within 90 miles Pediatric Emergency Med: Goal: 100% of membership within 90 miles Actual: 79.8% within 90 miles **Post Onsite Response:** Plan staff provided explanations for each provider type, and in each instance indicated that member access to these services are ensured through Single Case Agreements when and if needed. Efforts appear focused. Review determination unchanged.	Rheumatology - Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. c) Lab/X Ray - We continue to contract with any willing lab/X-ray providers as some are slightly more than 10 miles away for urban members. However, hospitals are not counted in this adequacy but they do provide these services. Rural: a) Pediatric Rheumatology – Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Emergency Med - Most of our Emergency Medicine providers have no age limitations, therefore they care for pediatric

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
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	1) Contracting Policy and Procedure	Substantial	Quarterly Geo Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in place from the available documentation. Nonetheless, network adequacy gap analysis indicates continued gaps in a number of areas, examples of which are: Urban (Certain Regions) a) Hand Surgery: Goal: 75% of membership within 60 miles Actual: 46.4% of membership within 60 miles b) Pediatric Rheumatology: Goal: 75% of membership within 60 miles Actual: 42.8% of membership within 60 miles c) Lab/X ray: Goal: 100% of members within 10 miles Actual: 89.7% within 10 miles Rural (Certain Regions) a) Pediatric Rheumatology: Goal: 100% of membership within 90 miles Actual: 59.8% within 90 miles Pediatric Emergency Med: Goal: 100% of membership within 90 miles Actual: 79.8% within 90 miles **Post Onsite Response:** Plan staff provided explanations for each provider type, and in each instance indicated that member access to these services are ensured through Single Case Agreements when and if needed. Efforts appear focused. Review determination unchanged.	As specified in our Quarterly Network Gap Analysis Urban: a) Hand Surgery - This is a very specific specialty and while we continually attempt to contract with new providers, there is a very limited number of Hand Surgeons in the state. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Rheumatology - Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. c) Lab/X Ray - We continue to contract with any willing lab/X-ray providers as some are slightly more than

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					10 miles away for urban members. However, hospitals are not counted in this adequacy but they do provide these services. Rural: a) Pediatric Rheumatology – Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Emergency Med - Most of our Emergency Medicine providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.11.1	The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed	1) Contracting Policy and Procedure 2) Contracting Policy and Procedure	Substantial	The referenced documents address all the elements of the requirement except the fist bullet point "Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered." Staff agreed with IPRO's finding and is in process of drafting a modification to the Network Selection and Retention Policy to include the 5%	Plan staff agreed and the policy has been updated

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: •Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. •A decrease in the total of individual PCPs by more than five percent (5%); •A loss of any participating specialist which may impair or deny the members' adequate access to providers; •A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or •Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.			of members change. Post Onsite Plan Response: Staff agreed and updated policy has been provided as a follow up. Review determination unchanged.	
Utilization Management					
8.4.4	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	1) BH Policy and Procedure	Substantial	Requirement addressed by: CCL.001 UM Program Description (p. 15) <u>Recommendation</u> Language regarding in or out-of-state mental hospitals is not found, and could be specified. **Post Onsite Plan Response:** Plan staff agrees and	A request for an Addendum F to be added to Cenpatico policy CCL.001 for immediate review and update. Please see below for the language for the addendum to

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				a Cenpatico policy addendum is in process	the policy. "Prior authorizations and concurrent utilization review for admission and concurrent stay for inpatient hospitals, specialty psychiatric hospitals (both in and outside of Louisiana), or state mental hospitals will be performed and documented for each admission."
Member Grievances and Appeals					
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	1) G& A Policy and Procedure	Substantial	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process; however, the sample Notice of Appeal Receipt does not communicate this requirement to the member. Nor does the Jane Doe Member Denial Letter address reasonable opportunity to present evidence. Recommendation: The plan should include with the Notice of Action and Appeal Acknowledgement letters an attachment that details this requirement (and each of the pertinent requirements not addressed in the body of each of these letters). **Plan response post onsite:** Plan provided templates of two changes made to the Notice of Disposition-Denial Letter, and the UM Denial Letter. Determination remains "Substantial."	The member is informed of his or her appeal rights with the UM letter, including the right to submit any other information for education and consideration prior to submitting the appeal. However, the recommendation to add this information to the acknowledgement letter is supported with action implemented to revise the Appeal Acknowledgement letter to "remind" and inform the member that he or she may also send in any other information in writing

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
					or by phone, which explains why we should pay for the service

Section 3: MCO Final Audit Tools

Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**				
6.4.5 6.4.5.1	**Permanent Supportive Housing** DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Bayou Health members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page / 1732/n/388. Overall management of the PSH program is centralized within DHH and final approval for members to participate in PSH is made by the DHH PSH program staff. For the Louisiana PSH program, the MCO shall:				
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	CM Work Process	Full	Addressed in LA.CM.21 Permanent Supportive Housing. Pg 1	
6.4.5.1.2	Assist members in completing the PSH program application;	CM Work Process	Full	Addressed in LA.CM.21 Permanent Supportive Housing. Pg 1-2	
6.4.5.1.3	Within one (1) working day of request by designated DHH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	1) Other Documents-Communication(s): Email responses to PSH program staff request.	Full	Addressed in : 1) secure RE SECURE - Authorization Check PSH Request (sample) 1 2) secure RE SECURE - Authorization Check PSH Request (sample) 2	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the DHH PSH program manager; and	N/A - requirement never implemented by LDH	N/A	N/A	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:				
6.4.5.2.1	Identify a PSH program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	1) Other Documents - 12/16/15 email confirming Chelsea Pottschmidt as PSH liaison from Michelle Brown. 2) Other Documents Email - Position Directory	Full	Addressed in: 1) FW Provider assignment PSH Liaison 2) "FW Updated Liaisons Information for LHCC"	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.	1) **Provider Manual**_Updated_FINAL-2016-06-15 2) Other Documents- BH Education Training	Full	Addressed in Provider Manual pg 148 Training	
6.4.9.1	The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	1) **Provider Manual**_Updated_FINAL-2016-06-15 2) Other Documents- BH Education Training	Full	Addressed in Provider Manual pg 148 Training Monitoring Clinical Quality	
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	1) **Provider Manual**_Updated_FINAL-2016-06-15 2) Other Documents- BH Education Training	Full	Addressed both in Provider Manual and via BH Education Training screening tools	
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral	1)UM/BH Policy and Procedure Policy 2) BH Policy and Procedure	Full	Addressed in : 1) CC.UM.14 Behavioral Health Care Assessment and Referral	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	3) Email		2)CSO.306 -Handling Incoming Crisis Calls 3) "FW Updated Liaisons Information for LHCC"	
6.8	**Emergency Medical Services and Post Stabilization Services**				
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	1) UM Policy and Procedure	Full	Addressed in UM 12 Pg 1 addresses this	
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	1) Member Handbook	Full	Addressed in Member Handbook pg 42	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services pg 2	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services pg 1	
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services pg 2	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	determination is binding on the MCO for coverage and payment.				
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services pg 2	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost- effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	1) Member Handbook 2) UM Policy and Procedure	Full	Addressed in LA.UM.16 Continuity and Coordination of Services pg 7	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	1) Member Handbook 2) Provider Manual	Full	Addressed in 1) Member handbook-Emergency Care 2) Provider Manual - Section Emergency Care Services	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.	1) CM Policy and Procedure	Full	CM 05 shows evidence of policies supporting monitoring of ER utilization. Evidence of implementation observed via Year To Date ED Visit Reports, which monitor ED visits by provider and by diagnosis.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	1) UM Policy and Procedure	Full	Addressed in LA.UM.01 - Medical Management Program Description	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:				
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services	
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: •Does not respond to a request for pre-approval within one hour; •Cannot be contacted; or •MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services	
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	1) UM Policy and Procedure	Full	Addressed in LA UM.12 Emergency and Post Stabilization Services policy links to CFR 422.113	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	1) UM Policy and Procedure	Full	Addressed in LA UM.12 Emergency and Post Stabilization Services policy links to CFR 422.113	
6.8.2.2.3	A representative of the MCO and the treating	1) UM Policy and Procedure	Full	Addressed in LA UM.12 Emergency	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	physician reach an agreement concerning the member's care; or			and Post Stabilization Services policy links to CFR 422.113	
6.8.2.2.4	The member is discharged.	1) UM Policy and Procedure	Full	Addressed in LA UM.12 Emergency and Post Stabilization Services policy links to CFR 422.113	
6.19	**Services for Special Populations**				
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:				
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;				
6.19.1.2	Individuals with intravenous drug use;				
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders;				
6.19.1.4	Substance using women with dependent children;				
6.19.1.5	Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;				
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and				
6.19.1.7	Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.				
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). DHH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with	1) CM Policy and Procedure 2) CM Work Process 3) Report (PASRR)	Full	Addressed via LA CM.01 Care Management Program Description. Utilization observed via 039 monitoring report, reflecting assessments conducted within 90 days of identification.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.				
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: •The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, DHH approved, guidelines for SHCN criteria. •MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. •Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. · Members may be identified by DHH and that information provided to the MCO.	1) CM Policy and Procedure 2) CM Work Process	Full	Addressed in 1)LA.CM.01.01 CM Assessment Process 2) LA.CM.01 Care Management Program Description	
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan and a person-centered plan of care. The individualized treatment plans must be:	1) CM Work Process 2) Other Documents	Full	Addressed in LA.CM.01.02 Care Plan Development and Implementation	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	1) CM Work Process 2) CM Policy and Procedure	Full	Addressed in LA.CM.01.02 Care Plan Development and Implementation	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.19.4.2	In compliance with applicable quality assurance and utilization management standards.	1) CM Policy and Procedure 2) IBH Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description	
6.19.4.3	SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a person- centered plan of care that includes all medically necessary services including specialized behavioral health services identified in the member's treatment plan.	1) CM Work Process 2) IBH Policy and Procedure	Full	Addressed in LA.IBH.01 Integrated BH Program Description	
6.27	**Care Management**				
6.27.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	1) CM Policy and Procedure	Full	Addressed in LA CM01 Case Management Program Description	
6.27.2 6.27.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	1) Provider Manual	Full	Addressed in Provider Manual pg 163	
6.27.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	1) UM Policy and Procedure	Full	Addressed in LA UM 01 Medical Management Program Description pg 6	
6.27.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health	1) CM Policy and Procedure	Full	Addressed in LA CM.01 Case Management Program Description	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	services.				
6.27.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 Case Management Program Description pg 30	
6.29	**Care Coordination, Continuity of Care, and Care Transition**				
6.29.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH or DHH's dental benefit program manager. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services And also Dental Benefits Program Description	
6.29.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition,	1) UM Policy and Procedure	Full	Addressed in LA.UM.16.01 Referrals to Specialty Health Care Services pg 2	

Core Benefits and Services					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.				
6.29.2	The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:				
6.29.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.2	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.3	Coordinate care for out-of-network services, including specialty care services;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	1) UM Policy and Procedure	Full	Addressed in LA UM.16 Continuity and Coordination of Services	
6.29.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	1) UM Policy and Procedure	Full	Addressed in LA UM.16.03 Continued Stay & Discharge Planning Review	
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	1) UM Policy and Procedure	Full	Addressed in LA UM.16.03 Continued Stay & Discharge Planning Review	
6.29.2.8.1.	Behavioral health pharmacy prior	1) Pharmacy Policy and	Full	Addressed in LA.PHAR.08 Pharmacy	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	Procedure		Prior Authorization and Medical Necessity	
6.29.2.8.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	1) IBH Policy and Procedure	Full	Addressed in LA.IBH.01 Integrated Behavioral Health Program Description	
6.29.2.8.3.	Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	1) BH Policy and Procedure	Full	Addressed in CCL.219 - Standards for Discharge Planning	
6.29.2.9	Document authorized referrals in its utilization management system; and	1) UM Policy and Procedure	Full	Addressed in LA.UM.16.01 Referrals to Specialty Health Care Services	
6.29.2.10	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.	1) UM Policy and Procedure	Full	Addressed in LA UM.16 - Continuity and Coordination of Services	
6.29.2.11	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffings.	1) Other Document	Full	Addressed in Judicial Court Liaison Description pgs 1-2	
6.29.2.12	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	Integrated BH Program Description	Full	Addressed in LA.IBH.01 Integrated BH Program Description	
6.35	**Continuity for Behavioral Health Care**				
6.35.1	The PCP shall provide basic behavioral health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	1) UM Policy and Procedure	Full	Addressed in LA.UM.16.01 Referrals to Specialty Healthcare Services	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.35.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: •Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; •Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; •The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; · It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.	1) IBH Policy and Procedure 2) **Provider Manual**_Updated_FINAL-2016-06-15	Full	Addressed in 1)LA.IBH.01 Integrated Behavioral Health Program Description 2)Integrated Care; Communication with Primary Care Physician; Medical Record Guidelines; Release of Information	
6.35.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	1) IBH Policy and Procedure	Full	Addressed in LA.IBH.01 Integrated Behavioral Health Program Description	
6.35.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	1) UM Policy and Procedure	Full	Addressed in LA.UM.12 Emergency and Post-Stabilization Services	
6.35.5	The MCO shall include documentation in the member's medical record that attempts are	1) CM Work Process	Full	Addressed in LA.CM.01.02 - Care Plan Development and	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	2) Policy LA.CM.01 Care Management Program Description		Implementation Screening and Assessment	
6.35.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	1) UM Policy and Procedure 2) Provider Manual_Updated_FINAL-2016-06-15	Full	Addressed in Policy LA.UM.16 - Continuity and Coordination of Services	
6.35.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.	1) IBH Policy and Procedure	Full	Addressed in LA.IBH.01 Integrated Behavioral Health Program Description	
6.35.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	1) IBH Policy and Procedure 2) **Provider Manual** Updated_FINAL-2016-06-15 3) Other Documents- BH Education Training 4)CM Workshop Training	Full	Addressed in 1) LA.IBH.01 Integrated Behavioral Health Program Description pgs 8 and 20 2) Clinical Training page 148 3) Provider Screening Tools 4) CM Workshop Power Point Revised 082216	
6.35.9 6.35.9.1.1 6.35.9.1.2 6.35.9.1.3 6.35.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: •Enhanced detection and treatment of behavioral health disorders in primary care settings; •Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; •Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;	1) IBH Policy and Procedure 2) **Provider Manual** Updated_FINAL-2016-06-15	Full	Addressed in 1) LA.IBH.01 Integrated Behavioral Health Program Description pg 5 2) Integrated Care pg 154	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	•Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with coexisting medical and behavioral health disorders requiring co- management				
6.35.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients	1) Other Documents	Full	Staff provided a BH Incentive Explanation Paper, explaining why financial incentives are not yet fully developed for the relatively new BH provider network. Examples of non financial incentives were described.	
6.35.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	1) **Provider Manua**l_Updated_FINAL-2016-06-15	Full	Addressed in Provider Manual Section(s): Release of Information - Clinical Training	
6.35.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	1. **Provider Manua**l_Updated_FINAL-2016-06-15 2) Member Handbook - Integrated	Full	Addressed in 1)Provider Manual_Updated_FINAL-2016-06-15 2) Member Handbook - Integrated	
6.35.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	1) UM Policy and Procedure 2) CM Policy and Procedure CC.CM.05 ED Diversion 3) IBH Policy and Procedure	Full	Addressed in 1) CC.UM.14 Behavioral Health Care Assessment and Referral pgs 1-2 2) CC.CM.05 Emergency Department Diversion pgs 1-3 3) LA.IBH.01 Integrated Behavioral Health Program Description pg 16	
6.35.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 Care Management Program Description pgs 20-21	
6.35.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	1) Other Documents - Clinical Documentation System (CDS) Screen Shot	Full	Addressed in Referrals 6.35.9.1.10	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	**1) Provider Manua**l_Updated_FINAL-2016-06-15	Full	Addressed in Provider Profiling and Incentive Programs –Provider Manual pg 69	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.35.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	1) Provider Manual_Updated_FINAL-2016-06-15 2) Other Documents- BH Education Training 3) CM Workshop PowerPoint - Revises 082216 4) Case Management Workshop handouts 09012016	Full	Addressed in Provider Manual_Updated_FINAL-2016-06-15 page(s) 133-134	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	1) Other Documents-ICT Rounds 2016	Full	Addressed in ICT Rounds 09.28.2016, ICT Rounds 10 25 2016 02, ICT Rounds Calendar Invitation, ICT Rounds for 08242016	
6.35.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with DHH representatives for the purpose of coordination and communication.	1) Other Documents-Meeting Notes and imbedded attachments	Full	Addressed in 2016 07 29 MCO Touch Base Notes	
6.38	**Case Management (CM)**				
6.38.1	The MCO shall develop and implement a case management program through a process which provides that appropriate and medically-related services, social services, and basic and specialized behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 14	
6.38.2	Case Management program functions shall include but not be limited to:				
6.38.2.1	Early identification , through active outreach,	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	of members who have or may have special needs;			Description pg 8	
6.38.2.2	Assessment of a member's risk factors;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.2.3	Education regarding patient-centered medical home and referral to a medical home when appropriate;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 28	
6.38.2.4	Development of an individualized treatment plan, in accordance with Section 6.19.4;	1) CM Work Process 2) Other Documents	Full	Addressed in 1) LA.CM.01.02 Care Plan Development and Implementation 2) CM Care Plan Example	
6.38.2.5	Referrals and assistance to ensure timely access to providers;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.2.7	Monitoring;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.2.8	Continuity of care; and	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.2.9	Follow-up and documentation.	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.38.3	Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19. A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.	1)IBH Policy and Procedure 2) CM Work Process	Full	Addressed in 1)LA.IBH.01 Integrated Behavioral Health 2)LA.CM.01.02 Care Plan Development and Implementation	
6.38.3.1	The MCO shall: •Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; •Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with	1) CM Policy and Procedure 2) Other Documents	Full	Addressed in 1) LA.CM.01 CM Program Description pg 21-24 2) CM Care Plan Example	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	the evaluation/assessment; •Ensure members are referred to service providers in accordance with freedom of choice requirement; •Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and •Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.				
6.39	**Case Management (CM) Policies and Procedures**				
6.39.0	The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 1	
6.39.1	A process to offer voluntary participation in the Case Management Program to eligible members;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 8	
6.39.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 14	
6.39.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: •Reproductive aged women with a history of prior poor birth outcomes; and •High risk pregnant women.	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 27	
6.39.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 21-24	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	cultural and				
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 21-24	
6.39.6	Procedures and criteria for making referrals to specialists and subspecialists;	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 21-24	
6.39.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 21-24	
6.39.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	1) CM Policy and Procedure	Full	Addressed in LA.CM.01 CM Program Description pg 21-24	
6.40	**Case Management Reporting Requirements**				
6.40	The MCO shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	1) LHC 039 Q2 2016 2) LHC 039 Q3 2016	Full	Addressed in 039 Quarterly Reporting	
6.40.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	1) LHC 039 Q2 2016 2) LHC 039 Q3 2016	Full	Addressed in 039 Quarterly Reporting	
6.40.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	1) LHC 039 Q2 2016 2) LHC 039 Q3 2016	Full	Addressed in 039 Quarterly Reporting	
6.40.3	Number of members identified with potential special healthcare needs that self- refer;	1) LHC 039 Q2 2016 2) LHC 039 Q3 2016	Full	Addressed in 039 Quarterly Reporting	
6.40.4	Number of members with potential special healthcare needs identified by the MCO;	1) LHC 039 Q2 2016 2) LHC 039 Q3 2016	Full	Addressed in 039 Quarterly Reporting	
6.40.5	Number of members in the lock-in program;	1) CM Policy and Procedure 2) Lock In Program Report	Full	Addressed in 1) LA.CM.01 CM Program Description 2) 6.40.5 Copy of RX 165 Lock-IN Jan 2016 - Aug 2016	
6.40.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	1) PASRR Report	Full	Addressed in 6.40.6 Copy of PASRR report q2 4-1-16 to 6-30-16 (002)	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.40.7	Number of members with assessments completed, and	1) Special Healthcare Needs Report	Full	Addressed in 1) 6.40.7 & 6.40.8 Copy of Copy of 039 LHC 2016 Q2 4	
6.40.8	Number of members with assessments resulting in a referral for Case Management.	1) Special Healthcare Needs Report	Full	Addressed in 1) 6.40.7 & 6.40.8 Copy of Copy of 039 LHC 2016 Q2 4	
6.41	**Chronic Care Management Program (CCMP)**				
6.41.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in 1) LA.CM.01 Case Management Program Description 2a) Asthma PD-Health Plan 2b) Back Pain Management PD Health Plan 2c) Diabetes PD-Health Plan 2d) Heart Failure PD-Health Plan 2e) Hepatitis C (HCY) Program Summary 2f) HIV - AIDS Program Summary 2g) Hypertension PD-Health Plan.doc 2h) Sickle Cell Disease Program Summary 2i) Weight Management PD-Health Plan	
6.41.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in 1) LA.CM.01 Case Management Program Description 2a) Asthma PD-Health Plan 2b) Back Pain Management PD Health Plan 2c) Diabetes PD-Health Plan 2d) Heart Failure PD-Health Plan	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				2e) Hepatitis C (HCY) Program Summary 2f) HIV - AIDS Program Summary 2g) Hypertension PD-Health Plan.doc 2h) Sickle Cell Disease Program Summary 2i) Weight Management PD-Health Plan	
6.41.4	The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	1) Other Documents	Full	As per plan, CCMP was submitted to LDH on time	
6.41.4.1	Include the definition of the target population;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.41.4.2	Include member identification strategies, i.e. through encounter data;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	
6.41.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				Weight Management PD-Health Plan	
6.41.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in 1) LA.CM.01 Case Management Program Description 2a) Asthma PD-Health Plan 2b) Back Pain Management PD Health Plan 2c) Diabetes PD-Health Plan 2d) Heart Failure PD-Health Plan 2e) Hepatitis C (HCY) Program Summary 2f) HIV - AIDS Program Summary 2g) Hypertension PD-Health Plan.doc 2h) Sickle Cell Disease Program Summary 2i) Weight Management PD-Health Plan	
6.41.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	
6.41.4.6	Include methods for informing and educating members and providers;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions 3) CM Policy and Procedure	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	
6.41.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	
6.41.4.8	Address co-morbidities through a whole-person approach;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in LA.CM.01 Case Management Program Description Asthma PD-Health Plan Back Pain Management PD Health Plan Diabetes PD-Health Plan Heart Failure PD-Health Plan Hepatitis C (HCY) Program Summary HIV - AIDS Program Summary Hypertension PD-Health Plan.doc Sickle Cell Disease Program Summary Weight Management PD-Health Plan	
6.41.4.9	Identify members who require in-person case management services and a plan to meet this need;	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in CCMP Program Description pg 7	
6.41.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in CCMP Program pg 8	
6.41.4.11	Include Program Evaluation requirements.	1) CM Policy and Procedure 2a-i) DM Programs Folder CCMP Program Descriptions	Full	Addressed in CCMP Program Description pg 25	
6.43	**CCMP Reporting Requirements**				
6.43.1	The MCO shall submit Chronic Care	1) Other Documents	Full	Addressed in- Evidence Submission	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.			042	
6.43.2	The CCMP reports shall contain at a minimum:				
6.43.2.1	Total number of members;	1) CCMP Report	Full	Addressed in Copy of 042 LHC 2016 Q3 7	
6.43.2.2	Number of members in each stratification level for each chronic condition; and	1) CCMP Report	Full	Addressed in Copy of 042 LHC 2016 Q3 7	
6.43.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	1) CCMP Report	Full	042 report provides disenrollment numbers "Nurtur" meeting minutes (6-29-16) contains breakdown of disenrollment by month and reasons—implementation demonstrated	
6.43.3 6.43.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	1) Other Documents 2) Other Documents 3) Reports 4) Reports 5a-b) Other Documents	Full	Addressed in 2016-10_LAG Report_final_11142016 (Evaluation of Sickle Cell, Hep C, HIV) QI7 Effectiveness Measure Report_CM 2015 (Sickle Cell) LouisianaHCC (Nurtur Quarterly Outcomes Report) LHCC Annual Nurtur Review 2015 HEP C Claims.Viral.Loads 2016 HEP C Claims.Viral.Loads	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**				
7.1.1	The MCO must maintain a network that ensures, at a minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy 3) LA.CONT.02 Network Selection and Retention	
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.	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Provider Relations Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention 3) LA PRVR 04 Provider Appointment Accessibility Standards	
7.1.3	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.				
7.1.4	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy	
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	1) Other Documents - Network Development & Management Plan (NDMP)	Full	Addressed in: 1) Network Development & Management Plan (NDMP)	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	ethnic backgrounds and provide for cultural competency and linguistic needs, health literacy, and other communication needs are provided. Assurances shall be achieved by: •Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); •Assessing the cultural competency of the providers on an ongoing basis, at least annually; •Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; •Assessing provider satisfaction of the services provided by the MCO at least annually; and •Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages,	2) Contracting Policy and Procedure 3) Provider Manual 4) Compliance Policy and Procedure		2) LA.CONT.01 Network Adequacy 3) Provider Manual - Section - Cultural Competency and Language Services 4) LA COMP 50 Organizational Cultural Competency	
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:				
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	1) Provider Relations Policy and Procedure 2) Other Documents 3) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2) LHC PPA Full Contract 3) Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	1) Provider Relations Policy and Procedure 2) Other Documents 3) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2) LHC PPA Full Contract 3) Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 LA PRVR 04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Appointment Accessibility Standards	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections Appointment Accessibility Standards	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Appointment Accessibility Standards	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	1) Provider Relations Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.PRVR.04 Provider Appointment Accessibility Standards 2)Provider Manual-Sections Appointment Accessibility Standards	
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	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy	
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	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Other Documents	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy 3) Medical Providers GEOS 2016 Q3	
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	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Other Documents	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy 3) Medical Providers GEOS 2016 Q3	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	parishes shall not exceed 10 miles.				
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.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Medical Providers GEOS 2016 Q3	
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.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Medical Providers GEOS 2016 Q3	
7.3.5 7.3.5.1 7.3.5.2	Pharmacies •Travel distance shall not exceed 10 miles in urban •Travel distance shall not exceed 30 miles in rural parishes; and parishes.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Medical Providers GEOS 2016 Q3	
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.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Medical Providers GEOS 2016 Q3	
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** **Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members**	1) Contracting Policy and Procedure 2) Other Documents	Full	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from	Plan's Response: Per RFP requirements, BH specialists' (inclusive of Psychiatrists, Psychologists, and APRNs) standards were met. Q4 Geo

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	living in rural parishes shall not exceed 30 miles for 90% of such members.			the available documentation. A review of the BH GEOS 2016 Q3 report indicated that there are members without access for the following provider groups (urban and rural), as examples: a) BH Specialists b)APRNs c)Medical Psychologists d) Psychiatrists **Post Onsite Plan Response:** Plan indicated BH Specialist Access Standards have been met as per RFP requirements, Q4 2016 Access standards were met. A re-review was conducted of Q3 2016 and it was indicated that standards were met. Review determination changed to "Full"	reports indicate 99% of rural members have access to a "BH specialist" within 30 miles. Furthermore, it should be noted that the RFP doesn't specify particular BH specialty provider types such as APRN, Psychiatrists, Medical Psychologists, etc…Per the RFP, Time and Distance to 'Behavioral Health Specialty Providers' requires that the travel distance shall not exceed 30 miles for 90% of rural membership and shall not exceed 15 miles for 90% of urban membership, which were met for Q4 2016.
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	1) Contracting Policy and Procedure 2) Other Documents	Full	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEOS 2016 Q3 report indicated that there are members without access for the following provider groups (urban and rural), as examples: a) BH Specialists b)APRNs c)Medical Psychologists d) Psychiatrists **Post Onsite Plan Response:** Plan indicated BH Specialist Access Standards have been met as per	Plan's Response: Per RFP requirements, BH specialists' (inclusive of Psychiatrists, Psychologists, and APRNs) standards were met. Q4 Geo reports indicate 99% of rural members have access to a "BH specialist" within 30 miles. Furthermore, it should be noted that the RFP doesn't specify particular BH specialty provider types such as APRN, Psychiatrists, Medical Psychologists, etc…Per the RFP, Time and Distance to 'Behavioral Health Specialty Providers' requires that the travel distance shall not exceed 30 miles for 90% of rural membership and shall not exceed 15 miles for 90% of

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				RFP requirements, Q4 2016 Access standards were met. A re-review was conducted of Q3 2016 and it was indicated that standards were met. Review determination changed to "Full"	urban membership, which were met for Q4 2016.
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults Post Onsite Plan Response: Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults **Post Onsite Plan Response:** Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	1) Contracting Policy and Procedure 2) Other Documents	Substantial	Quarterly GEO Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in line from the available documentation. A review of the BH GEO Q3 reports indicated members without access for ASAM III 3 and III 5 Providers-Adults **Post Onsite Plan Response:** Links recently received to the Health Standards Provider Directory, per LDH, and the plan has begun compiling a target list for contract outreach. Efforts continue underway to expand the network of these providers. Review determination unchanged.	LHCC recently received links to the Health Standards Provider Directory, per LDH, and has begun compiling a target list for contract outreach. Through this targeting outreach we plan to grow our network of these providers and ultimately achieve network adequacy. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) BH GEOS 2016 Q3	
7.3.7.7	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
7.3.7.8	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
7.4.1	Provider to Member Ratios The MCO must demonstrate that their network has a sufficient number of providers	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
7.5	**Monitoring and Reporting on Provider Networks**				
7.5.1 7.5.1.1	Appointment Availability Monitoring The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Provider Manual 4) Member Handbook 5) Provider Relations Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.01 Network Adequacy 3) Provider Manual - Section - Appointment Accessibility Standards 4) Member Handbook- Section Appointment Waiting Times 5) LA.PRVR.04 Provider Appointment Accessibility Standards	
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure 3) Other Documents 4) Other Documents 5) Other Documents 6) Other Documents	Substantial	Quarterly Geo Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in place from the available documentation. Nonetheless, network adequacy gap analysis indicates continued gaps in a number of areas, examples of which are: Urban (Certain Regions) a) Hand Surgery: Goal: 75% of membership within 60 miles Actual: 46.4% of membership within 60 miles b) Pediatric Rheumatology: Goal: 75% of membership within 60 miles Actual: 42.8% of membership within 60 miles	As specified in our Quarterly Network Gap Analysis Urban: a) Hand Surgery - This is a very specific specialty and while we continually attempt to contract with new providers, there is a very limited number of Hand Surgeons in the state. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Rheumatology - Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Development Plan.			c) Lab/X ray: Goal: 100% of members within 10 miles Actual: 89.7% within 10 miles Rural (Certain Regions) a) Pediatric Rheumatology: Goal: 100% of membership within 90 miles Actual: 59.8% within 90 miles Pediatric Emergency Med: Goal: 100% of membership within 90 miles Actual: 79.8% within 90 miles **Post Onsite Response:** Plan staff provided explanations for each provider type, and in each instance indicated that member access to these services are ensured through Single Case Agreements when and if needed. Efforts appear focused. Review determination unchanged.	Agreements if needed. c) Lab/X Ray - We continue to contract with any willing lab/X-ray providers as some are slightly more than 10 miles away for urban members. However, hospitals are not counted in this adequacy but they do provide these services. Rural: a) Pediatric Rheumatology – Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Emergency Med - Most of our Emergency Medicine providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.	1) Contracting Policy and Procedure 2) Other Documents	Full	1) LA.CONT.01 Network Adequacy 2) PI220 Network Adequacy Review 2016 Q3	
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	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services) and all providers approved by the DHH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.	Procedure 3) Other Documents		3) Ryan White Facilities	
7.6.1.1.1	The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH: •Rural Health Clinics (RHCs); •Local Governing Entities; •Federally Qualified health Centers; •Methadone Clinics pending CMS approval; •Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D); •Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Mental Health Rehabilitation (MHR) Agencies;	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).				
7.6.1.2	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	
7.6.1.3	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	
7.6.1.4	The provisions above (7.6.1.2 and 7.6.1.3) do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	
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)].	1) Other Documents - Network Development & Management Plan (NDMP) 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development & Management Plan (NDMP) 2) LA.CONT.02 Network Selection and Retention	
7.6.1.6	The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	1) Other Documents	Full	Addressed in: FW DHH-MCO Weekly Specialized Behavioral Health Integration Noon Provider Calls	
7.6.2	Exclusion from Participation -	1) Credentialing Policy and	Full	Addressed In:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.6.2.1	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Procedure 2) Other Documents-Network Development and Management Plan		1) CC.CRED.01 Practitioner Credentialing and Recredentialing 2) Network Development and Management Plan	
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)].	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure 3) Credentialing Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.02 Network Selection and Retention 3) CC.CRED.04 Nondiscriminatory Credentialig and Recredentialing	
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	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
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.	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.23 Provider Termination Policy 2) Alternatives Living Mandatory Term Notice_7.6.3.3	
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	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.23 Provider Termination Policy	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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).				
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.	1) Contracting Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Provider Manual- Mainstreaming	
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:	1) Contracting Policy and Procedure 2) Provider Manual 3) Member Handbook	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Provider Manual -Mainstreaming 3) Member Handbook Section Member Rights	
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	1) Other Documents	Full	Addressed in : 1) LHC PPA Full Contract pg 4	
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.	1) Other Documents	Full	Addressed in: LHC PPA Full Contract	
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.	1) Other Documents 2) Provider Manual	Full	Addressed in: 1) LHC PPA Full Contract 2) Provider Manual-Mainstreaming	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30)	1) Contracting Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) LA.CONT.02 Network Selection & Retention 2) Provider Manual-Mainstreaming	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	calendar days and notify DHH in writing				
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	1) Contracting Policy and Procedure 2) Provider Manual	Full	1) LA.CONT.02 Network Selection & Retention 2) Provider Manual-Mainstreaming	
7.8.2	**Primary Care Provider Responsibilities**				
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:				
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
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;	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
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;	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
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;	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
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	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and all state statutes.				
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.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	1) Provider Manual	Full	Addressed in: 1) Provider Manual-Provider Responsibilities Recommendation: The plan should consider modifying Medical Record Audit Tool to include this element for PCP monitoring and oversight purposes **Post onsite plan response:** Plan staff agreed and audit tool modification is underway.	Plan agreed, the current audit tool is under active review specific to member needs for behavioral health services. The review is expected to be completed and additions to the tool ready for implementation for the 2018 provider audit cycle.
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.				
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	1) Contracting Policy and Procedure	Full	Addressed in : PI 220 report: Network Adequacy Review-Pediatric specialties	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
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	1) Contracting Policy and Procedure	Substantial	Quarterly Geo Access reports are submitted, along with appropriate attestations and gap analysis monitoring. Oversight of provider availability appears well in place from the available documentation. Nonetheless, network adequacy gap analysis indicates continued gaps in a number of areas, examples of which are: Urban (Certain Regions) a) Hand Surgery: Goal: 75% of membership within 60 miles Actual: 46.4% of membership within 60 miles b) Pediatric Rheumatology: Goal: 75% of membership within 60 miles Actual: 42.8% of membership within 60 miles c) Lab/X ray: Goal: 100% of members within 10 miles Actual: 89.7% within 10 miles Rural (Certain Regions) a) Pediatric Rheumatology: Goal: 100% of membership within 90 miles Actual: 59.8% within 90 miles Pediatric Emergency Med: Goal: 100% of membership within 90 miles Actual: 79.8% within 90 miles **Post Onsite Response:** Plan staff provided explanations for each provider type, and in each instance indicated that member access to	As specified in our Quarterly Network Gap Analysis Urban: a) Hand Surgery - This is a very specific specialty and while we continually attempt to contract with new providers, there is a very limited number of Hand Surgeons in the state. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. b) Pediatric Rheumatology - Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed. c) Lab/X Ray - We continue to contract with any willing lab/X-ray providers as some are slightly more than 10 miles away for urban members. However, hospitals are not counted in this adequacy but they do provide these services. Rural: a) Pediatric Rheumatology – Most of our Rheumatology providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				these services are ensured through Single Case Agreements when and if needed. Efforts appear focused. Review determination unchanged.	Agreements if needed. b) Pediatric Emergency Med - Most of our Emergency Medicine providers have no age limitations, therefore they care for pediatric patients as well. LHCC ensures member access to these provider types through out of network Single Case Agreements if needed.
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.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
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.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.				
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. MCO must establish access to the following within their network of hospitals: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	
7.8.4.3	The MCO may contract with out-of-state	1) Contracting Policy and	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hospitals in the trade area.	Procedure 2) Other Documents-Network Development and Management Plan		1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan 3) Provider Manual	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	
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	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.01 Network Adequacy 2) Network Development & Management Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.				
7.8.6.2	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development & Management Plan	
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.	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development & Management Plan	
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.	Eligibility Policy and Procedure	Full	Addressed in: LA.ELIG.04 Primary Care Provider (PCP)Auto Assignment	
7.8.8	Other Service Providers The MCO shall ensure the availability of	1) Other Documents-Network Development and	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	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.	Management Plan		1) Network Development and Management Plan	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan 3) Other Document 4) Other Document	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Network Development and Management Plan 3) Health Services of North Louisiana FQHC-RHC Final Executed CONTRACT #31754 4) Iberia Comprehensive Community FQHC Final Executed CONTRACT #25014	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan 3) Other Document 4) Other Document	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Network Development and Management Plan 3) St. Gabriel Health Clinic, Inc. Final Executed SBHC CONTRACT #26917 4) Our Lady of the Lake Physician Group HC Ctrs in School Final Executed Contract #40139	
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	1) Contracting Policy and Procedure 2) Other Documents	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	within the parish health units (e.g. immunizations, STD, family planning).	3) Other Documents 4) Other Documents-Network Development and Management Plan		2) St. Gabriel Health Clinic, Inc. Final Executed SBHC CONTRACT #26917 3) Our Lady of the Lake Physician Group HC Ctrs in School Final Executed Contract #40139 4) Network Development and Management Plan	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Network Development and Management Plan 3) Louisiana Department of Health & Hospital Office of Public Health Final Executed Contract #32494	
7.8.14 7.8.14.1	Specialized Behavioral Health Providers The MCO shall work with the existing network of behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	1) Contracting Policy and Procedure	Full	Addressed in: LA.CONT.02 Network Selection and Retention	
7.8.14.4	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing required peer services (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or	1) Contracting Policy and Procedure 2) Other Documents b) Reports	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2a) Coordinated System of Care (CSoC) Liaison b) Copy of 313_Access_to_Wraparound-	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	CPST).	3)Other Documents 4) Other Documents		MCO_Q1 3) "Peer Services" and "Peer Liaison Tracker." 4) Judicial Liaison Tracker	
7.8.14.5	The MCO shall ensure that within the provider network, members enrolled in Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	1) Contracting Policy and Procedure 2) Other documents 3) Other Documents	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Bayou Health Behavioral Health Assessment -Member Signature 3) UM Snips Freedom of Choice	
7.8.14.7	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. The community- based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management and intervention, mobile crisis teams, and crisis stabilization in an alternative settings. If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.	1) Contracting Policy and Procedure 2) Member Handbook 3) Service Operations Policy and Procedure 4) Other Documents	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention 2) Member Handbook 3) CSO.306 Handling Incoming Crisis Calls 4) BH SCAs 12_2015 to 04_2016	
7.8.14.9	The MCO shall require behavioral health providers to screen for basic medical issues,	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.	2) Provider Manual 3a) Other Documents 3b) Other Documents		and Retention 2) Provider Manual 3a) Bayou Health Behavioral Health Assessment 3b) NEW OTR FORM LA_GeneralOutpatientTreatmentRequestForm_Provider_8292016	
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):	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Pages 1-3 (Entire Policy) 2) Pages 1-18 (Entire Document	
7.9.1.1	Anticipated maximum number of Medicaid members;	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Plan 2) Network Development and Management Plan	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Plan 2) Network Development and Management Plan	
7.9.1.3	The numbers and types (in terms of training,	1) Contracting Policy and	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Procedure 2) Other Documents-Network Development and Management Plan		1) LA.CONT.05 Network Development & Management Plan 2) Network Development and Management Plan	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Plan 2) Network Development and Management Plan	
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Plan 2) Network Development and Management Plan	
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.1	Assurance of Adequate Capacity and Services	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.2	Access to Primary Care Providers	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.3	Access to Specialists	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.4	Access to Hospitals	1) Other Documents-Network Development and	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Management Plan 2) Contracting Policy and Procedure		1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.5	Access to Behavioral Health Services	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
7.9.2.6	Timely Access	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	
7.9.2.7	Service Area	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	
7.9.2.8	Other Access Requirements: Direct Access to Women's Health , Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.01 Network Adequacy	
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.	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	
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.	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.02 Network Selection and Retention	
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	1) Contracting Policy and Procedure	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	changes and requirements;			1) LA.CONT.05 Network Development & Management Plan	
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;	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Plan	
7.9.5.3	Evaluate the quality of services delivered by the network;	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development & Management Plan	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	1) Other Documents-Network Development and Management Plan 2) Contracting Policy and Procedure	Full	Addressed in: 1) Network Development and Management Plan 2) LA.CONT.05 Network Development & Management	
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	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.05 Network Development & Management	
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;	1) Credentialing Policy and Procedure 2) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 Practitioner Credentialing and Recredentialing 2) CC.CRED.04 Nondiscriminatory Credentialing and Recredentialing	
7.9.5.7	Provide training for its providers and maintain records of such training;	1) Provider Relations Policy and Procedure	Full	Addressed in: 1) LA.PRVR.13 Provider Orientation & Ongoing Training	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	1) Provider Relations Policy and Procedure	Full	Addressed in: LA.PRVR.03 Provider Complaints	
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days	1) Provider Relations Policy and Procedure	Full	Addressed in: LA.PRVR.03 Provider Complaints	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.				
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.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management Network 2) Development and Management Plan	
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.		Full	Addressed in: 1) LA.CONT.05 Network Development & Management 2) Network Development and Management Plan	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: •The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and Management Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	contract;				
	•The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) LA.CONT.05 Network Development & Management 2) Network Development and Management Plan	
	•GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH quarterly by contract year, upon material change of the network, or upon request;	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	
	•An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include: •Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services; •Specialized behavioral health service needs of members; and •Growth trends in eligibility and enrollment, including: Current and anticipated numbers of Title XIX and Title XXI eligibles; and Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.	1) Contracting Policy and Procedure 2) Other Documents 3) Other Documents 4) Other Documents 5) Other Documents 6) Other Documents	Full	Addressed in: 1) LA.CONT.01 Network Adequacy; 2) SCA Pull 3a) PASRR Pull 3b) "Bayou Health flow chart detail_10-16-15" 3) "277 11.18" Members with needs assessments 5) BH SCAs 12_2015 to 04_2016 6) BH GEOS 2016 Q3	
	•Accessibility of services, including: The number of current qualified specialized behavioral health service providers by individual specialized behavioral health	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.01 Network Adequacy	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and Any service access standards detailed in a SPA or waiver.				
7.9.8.3	The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health provider profiling data, which shall include: •Member eligibility/enrollment data; •Specialized behavioral health service utilization data; •The number of single case agreements by specialized behavioral health service type; •Specialized behavioral health treatment and functional outcome data; •The number of members diagnosed with developmental/cognitive disabilities; •The number of prescribers required to meet specialized behavioral health members' medication needs; •The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; •Provider grievance, appeal and request for arbitration data; and •Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.	1) Contracting Policy and Procedure 2) Other Documents-Network Development and Management Plan 3) Report	Full	Addressed in: 1) LA.CONT.05 Network Development & Management 2) Network Development and Management Plan 3) Copy of 320 Behavioral Health Treatment Outcomes Report - Q2 2016	
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that:	1) Other Documents-Network Development and Management Plan 2a-c) Other Documents-	Full	Addressed in: 1) Network Development and Management Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	•Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; •Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; •Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; •Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and •Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.	Letters		2a) Adult Services Letter- "A.Davis Adult-List of Resources" b) Child Services Letter- "Mckenzie M Provider List-Minor" c) McClure N Resource Letter	
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: •Includes specific specialized behavioral health services for children; •Targets the development of family and community-based services for children/youth in out-of-home placements; •Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and •Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.		Full	Addressed in: 1) Network Development and Management Plan 2) 318_Utilization_of_HCBS_Report - Dec 15 to June 16	
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to	1) Other Documents-Network Development and Management Plan	Full	Addressed in: 1) Network Development and	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: •Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); •Assessing the cultural competence of the providers on an ongoing basis, at least annually; •Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; •Assessing provider satisfaction of the services provided by the MCO at least annually; and •Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.	2) Quality Improvement Policy and Procedure		Management Plan 2) LA.QI.04 Evaluation of Practitioner Availability	
7.9.8.7	The Network Development and Management	1) Other Documents-Network	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Development and Management Plan		1) Network Development and Management Plan	
7.11	**Material Change to Provider Network**				
7.11.1	The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: •Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. •A decrease in the total of individual PCPs by more than five percent (5%); •A loss of any participating specialist which may impair or deny the members' adequate access to providers; •A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or •Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.	1) Contracting Policy and Procedure 2) Contracting Policy and Procedure	Substantial	The referenced documents address all the elements of the requirement except the fist bullet point "Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered." Staff agreed with IPRO's finding and is in process of drafting a modification to the Network Selection and Retention Policy to include the 5% of members change. Post Onsite Plan Response: Staff agreed and updated policy has been provided as a follow up. Review determination unchanged.	Plan staff agreed and the policy has been updated
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services,	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	payments, or eligibility of a new population.				
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.11.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite				
7.11.6	The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: •Information about how the provider network change will affect the delivery of covered services, and •The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.23 Provider Termination	
7.11.8	As it pertains to a material change in the	1) Contracting Policy and	Full	Addressed in:	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.11.8.1	network for behavioral health providers, the MCO shall also: Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: •A decrease in a behavioral health provider type by more than five percent (5%); •A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or •A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by DHH.	Procedure		1) LA.CONT.02 Network Selection and Retention	
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: •Detailed information identifying the affected provider; •Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	program category; •Location and identification of nearest providers offering similar services; and •A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.				
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	
7.12	**Coordination with Other Service Providers**				
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of	1) Contracting Policy and Procedure	Full	Addressed in: 1) LA.CONT.02 Network Selection and Retention	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the enrollee).				
7.13	**Provider Subcontract Requirements**				
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	1) Contracting Policy and Procedure 2) Other Documents - Network Development & Management Plan (NDMP)	Full	Addressed In: 1) LA.CONT.02 Network Selection and Retention 2) Network Development & Management Plan (NDMP)	
7.14	**Credentialing and Recredentialing of Providers and Clinical Staff**				
7.14.1	The MCO must have a written credentialing and re- credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.1.1	Prior to subcontracting, the MCO shall follow DHH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with: •The Council on Accreditation (COA); •The Commission on Accreditation of Rehabilitation Facilities (CARF); or •The Joint Commission (TJC).	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.09 Organizational Assessment and Reassessment	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	1) Credentialing Policy and Procedure 2) Provider Manual	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing 2) Provider Manual- Section Credentialing and Recredentialing	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. “Completely process” shall mean that the MCO shall:	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.5.2	Submit on the weekly electronic Provider Directory to DHH or DHH’s designee; or	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance	1) Credentialing Policy and Procedure 2) Other Documents	Full	Addressed in: 1) CC.CRED.12 Oversight of Delegated Credentialing 2) Our Lady of the Lake Physician Group Delegated Contract #40139	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	with DHH's credentialing requirements.				
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.12 Oversight of Delegated Credentialing	
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.12 Oversight of Delegated Credentialing	
7.14.9	The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	1) Credentialing Policy and Procedure 2) Other Documents 3) Other Documents	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing 2) Bayou Health Behavioral health Assessment 3) New OTR Form LA General Outpatient Treatment request form	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	1) Credentialing Policy and Procedure 2) Credentialing Policy and Procedure 3) Credentialing Policy and Procedure 4) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.01 - Practitioner Credentialing & Recredentialing 2) CC.CRED.06 - Ongoing Monitoring of Sanctions and Complaints 3) CC.CRED.07 - Practitioner Disciplinary Action and Reporting 4) CC.CRED.08 - Practitioner Appeal Hearing Process	
7.14.12	The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.07 - Practitioner Disciplinary Action and Reporting	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and at the time of any change.				
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	1) Credentialing Policy and Procedure	Full	Addressed in: 1) CC.CRED.08 Practitioner Appeal Rights and Hearing Process	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.				
7.16	**Provider-Member Communication Anti-Gag Clause**				
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	1) Provider Manual 2) Other Documents	Full	Addressed in: 1) Provider Manual-Rights and Responsibilities 2) LHC PPA Full Contract	
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	1) Provider Manual 2) Other Documents	Full	Addressed in: 1) Provider Manual-Rights and Responsibilities 2) LHC PPA Full Contract	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	1) Provider Manual 2) Other Documents	Full	Addressed in: 1) Provider Manual-Rights and Responsibilities 2) LHC PPA Full Contract	
7.16.1.3	The risks, benefits and consequences of treatment or non- treatment; and	1) Provider Manual 2) Other Documents	Full	Addressed in: 1) Provider Manual-Rights and Responsibilities	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				2) LHC PPA Full Contract	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	1) Provider Manual 2) Other Documents	Full	Addressed in: 1) Provider Manual-Rights and Responsibilities 2) LHC PPA Full Contract	
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.				
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	1) Other Documents - Network Development & Management Plan (NDMP)	Full	Addressed in: 1) Network Development & Management Plan (NDMP)	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
8.1	**General Requirements**				
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.01 - Medical Management Program Description (p. 6 *electronic)* (BH) CCL.001 UM Program Description (p. 1) *Cenpatico* Please briefly describe the relationship between the PH and BH units? Integration of P/P is commendable.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:				
8.1.2.1	Are adopted in consultation with contracting health care professionals;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1) (BH) CCL.001 UM Program Description (p. 6)	
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1) (BH) CCL.001 UM Program Description (p.10-11)	
8.1.2.3	Are considerate of the needs of the members; and	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1) (BH) CCL.001 UM Program Description (p. 11)	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1) (BH) CCL.001 UM Program Description (p. 1)	
8.1.3	The policies and procedures shall include, but not be limited to:				
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1-2) (BH) CCL.001 UM Program Description (throughout)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.3.2	The data sources and clinical review criteria used in decision making;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1-2) (BH) CCL.001 UM Program Description (p. 10-11)	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 4) (PH) LA UM.02 Clinical Decision Criteria & Application (throughout)	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 6-7)	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 4) (BH) CCL.001 UM Program Description (p. 11)	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH - member) LA UM 06 Clinical Information and Documentation (p. 1) (PH - population) LA UM.01 - Medical Management Program Description (p. 9) (BH - member) CCL.001 UM Program Description (p. 11) BH - population) CCL.001 UM Program Description (p. 6-8, 18)	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and PH) LA UM.01 - Medical Management Program Description (p. 7) (BH) CCL.001 UM Program Description (p. 7, 18-19)	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	1) UM Policy and Procedure 2) BH UM Policy	Full	Requirement addressed by: (PH and BH) LA UM.01 - Medical Management Program Description (p. 25 electronic) (BH) CCL.001 UM Program Description Program Scope / Decision Making Criteria (p. 5, 10-	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				11)	
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	1) BH Policy and Procedure	Full	Requirement addressed by: (PH and BH) CCL.219 Standards for Discharge Planning - Attachment A (p. 5)	
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	1) BH Policy and Procedure	Full	Requirement addressed by: (PH and BH) CCL.219 Standards for Discharge Planning - Attachment A (throughout)	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	1) BH Policy and Procedure	Full	Requirement addressed by: (PH and BH) CCL.219 Standards for Discharge Planning - Attachment A (p. 5)	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	1) BH Policy and Procedure	Full	Requirement addressed by: (PH and BH) CCL.219 Standards for Discharge Planning - Attachment A (p. 5)	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1-2) (BH) CCL.001 UM Program Description (p. 10-11). Cenpatico utilizes national professional organization CPGs, and federal, state, and Medicaid regulations.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 2-3) (BH) CCL.001 UM Program	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Description (p. 11 providers, p. 16 members).	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	1) BH Policy and Procedure 1) Other Documents	Full	Requirement addressed by: Cenpatico 2015 QI Program Evaluation (p. 8-19), although LA was not yet included. BH CPG Adherence - report by provider. On interview, the MCO offered an in-depth status regarding incentive development for BH providers. The BH contract has been in place for less than one year, with limited time for evaluation. Network development and provider education regarding credentialing application, documentation, and billing were prioritized for the first few months of contract implementation. Continuity of care required all prior services to be authorized for a three month period. A multi-million dollar budget cut resulted in reductions in monetary incentives generally. And since BH providers do not maintain member panels, many non-monetary incentives have been created: town halls, formal clinical training (covered benefits, medical necessity criteria, SMART goals, cultural competence, screening tools, diagnostic manuals), one-on-one attention for claims submission and payment, and continued network participation. The MCO is also implementing co-location and reverse co-location models of care.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	1) UM Policy and Procedure	Full	Requirement addressed as cited at 8.1.2.2	
8.1.6.1	The vendor must be identified if the criteria	1) UM Policy and Procedure	Full	Requirement addressed as cited at	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	was purchased;			8.1.2.2	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	1) UM Policy and Procedure 2.Provider Manual 3) QI Policy and Procedure	Full	Requirement addressed as cited at 8.1.2.2 and: (PH and BH) LA.QI.08 Adopted Clinical Practice and Preventive Health Guidelines (p. 7-11) Provider Manual (p. 63)	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	1) UM Policy and Procedure	Full	Requirement addressed as cited at 8.1.2.2	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 1, 3)	
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	1) Provider Manual 2) Member Handbook 3) Tracking Disclosure of Medical Necessity Criteria 4) QI Policy and Procedure	Full	Requirement addressed as cited at 8.1.5 and 8.1.3.5 and: Provider Manual (p. 84) Member Handbook - Integrated (p. 47) (PH and BH) LA.QI.08 Adopted Clinical Practice and Preventive Health Guidelines (p. 3-4) (PH) LA UM.02.13 Tracking Disclosure of Medical Necessity Criteria (p. 1)	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	1) UM Policy and Procedure	Full	Requirement addressed as cited at 8.1.3.6. Recommendation The P/P LA UM.06 -Clinical Information & Documentation could add a statement that procedures will be given verbally to covered person or provider. **Post Onsite Plan Response:** Plan staff agreed and the policy is being reviewed for the change	Policy to be reviewed for appropriate language at the next policy meeting.
8.1.9	The MCO shall have written procedures to	1) UM Policy and Procedure	Full	Requirement addressed by:	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.			(PH and BH) LA UM.06 - Clinical Information & Documentation (p. 3)	
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: Specialized behavioral health services, and PSH to ensure appropriate authorization of tenancy services.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 3) On interview, the MCO submitted organizational charts demonstrating multiple clinical coverage review nurses, office and field-based, throughout the state. Also represented were Prior Authorization, IP and OP UM, Care Coordination, ICM and DM personnel, as well as staff dedicated to Referrals, Transportation, Special Ops and Correspondence Review.	
8.1.11	The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.02 Clinical Decision Criteria & Application (p. 1)	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 4)	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 2)	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	1) UM Policy and Procedure 2) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 2) (PH and BH) LA.UM.07 - Adverse Determination (Denial) Notices (p. 1)	
8.1.16	The individual(s) making these determinations shall have no history of	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.			UM Professionals (p. 1)	
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.04 Appropriate UM Professionals (p. 1)	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.01.01 - Covered Benefits & Services (p. 1 and 2)	
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH) LA UM.04.01 Affirmative Statement About Incentives (p. 1) (BH) CCL.001 UM Program Description (p. 12)	
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.01 - Medical	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization and post authorization.			Management Program Description (BH) CCL.001 UM Program Description (p. 5)	
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert and Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:	1) UM Policy and Procedure	Full	Requirement addressed by LA UM01 Medical Management Program Description pg.10-11, and by LA UM05 Timeliness of UM Decisions and Notification , pg.1	
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p.1, 2) (BH) CCL.229 Utilization Management Timeliness and Notification Standards (p. 4)	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	1) UM Work Process	Full	Requirement addressed by: (PH) LA UM.02.05 - Interrater Reliability Testing (p. 1 and throughout) (BH) (PH and BH) LA UM.01 - Medical Management Program Description (p. 11)	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	1) UM Work Process	Full	Requirement addressed as cited at 8.1.15 and by: (PH) LA.UM.02.01 - Medical Necessity Review (p. 2) (BH) CCL.240 Utilization Review (p. 1) (Cenpatico)	
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	1) Member Handbook 2) UM Program Description 2016	Full	Requirement addressed by: (PH and BH) Member Handbook - Integrated (p. 41, 47)	
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-	1) UM Policy and Procedure	Full	Requirement addressed by: (PH) LA UM.06.04 - TruCare Standards for Documentation (p. 1)	Staff agrees, will be addressed in an upcoming policy meeting for discussion and update.

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	participating providers; and			Recommendation On interview, the MCO confirmed Cenpatico also uses the TruCare authorization system. The Cenpatico UM PD section Information Management System (p. 11) currently does not detail the required attributes, which could be included. **Post Onsite Plan Response:** Staff agrees, to be discussed at an upcoming policy meeting.	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	1) UM Policy and Procedure	Full	Requirement addressed as cited at 8.4.2.4.	
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	1) UM Work Process	Full	Requirement addressed by: (PH) CC.UM.01.08 - Use of Out-of-Network Providers and Steerage (p. 1) (BH) CCL.240 Utilization Review (p. 12)	
8.4.4	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	1) BH Policy and Procedure	Substantial	Requirement addressed by: CCL.001 UM Program Description (p. 15) Recommendation Language regarding in or out-of-state mental hospitals is not found, and could be specified. **Post Onsite Plan Response:** Plan staff agrees and a Cenpatico policy addendum is in process	A request for an Addendum F to be added to Cenpatico policy CCL.001 for immediate review and update. Please see below for the language for the addendum to the policy. "Prior authorizations and concurrent utilization review for admission and concurrent stay for inpatient hospitals, specialty psychiatric hospitals (both in and outside of Louisiana), or state mental hospitals will be performed and documented for each admission."
8.4.4.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization	1) BH Policy and Procedure	Full	Requirement addressed by: CCL.001 UM Program Description	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].			(p. 9). See specification regarding psychiatric admission to general hospitals (p. 12).	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	1) BH Policy and Procedure	Full	Documentation of medical necessity review for inpatient psychiatric treatment is addressed by: (BH) CCL.240 Utilization Review (p. 3)	
8.4.4.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or	1) Email Communications with LDH. 2) Email Summary of Discussion with LDH (Summary of discussions with LDH regarding this section of RFP - LDH notified that Emergency Departments do not notify the MCO when member presents in crisis. MCO is notified within 24 hours of admission after member is stabilized and in a place of safety)	Full	Requirement addressed by: Email communications between the MCO and LDH regarding the required entry in Report 188 dated 7/21/16 and 8/4/16. The MCO auto-authorizes all ED services, and is notified 24 hours after an admission (no screen is requested or performed).	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the				

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.				
8.4.4.4	Certification of Need for PRTFs				
8.4.4.4.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.				
8.4.4.4.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	1) MM Work Process (see policy and procedures folder)	Full	Requirement addressed by: Psychiatric Residential Treatment Facilities (PRTF Process) (p. 2)	
8.4.4.4.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	1) MM Work Process (see policy and procedures folder)	Full	Requirement addressed by: Psychiatric Residential Treatment Facilities (PRTF Process) (p. 1)	
8.4.4.4.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	1) MM Work Process (see policy and procedures folder)	Full	Requirement addressed by: Psychiatric Residential Treatment Facilities (PRTF Process) (p. 3)	
8.4.4.4.5	In addition to certifying the need, the MCO shall: •Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. •Ensure that PRTF certification, including the	1) MM Work Process (see policy and procedures folder) 2) PRTF Workflow 3) CBH Policy and Procedure	Full	Requirement addressed by: Psychiatric Residential Treatment Facilities (PRTF Process) (p. 3) CCL.229 Utilization Management Timeliness and Notification Standards (p. 2)	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	independent certification, are forwarded to the admitting facility. •Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal, and the process to do so. •Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. •Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. •Work with the Medicaid Fiscal Intermediary to determine retroactive eligibility and assignment, when applicable. •Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.			On interview, the MCO confirms working with the Medicaid Fiscal Intermediary to determine retroactive eligibility.	
8.4.5	At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.	Note: TFC not added as Medicaid Benefit/No current presence on Fee schedule	N/A	On interview, the MCO confirms Therapeutic Foster Care has not yet been added as a Medicaid Benefit.	
8.5	**Timing of Service Authorization Decisions**				
8.5.1	**Standard Service Authorization**				
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 2) TAT snapshot of the most recent quarter shows standards met	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.				
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 5) TAT snapshot of the most recent quarter shows standards met for BH, performance within 3-5 percentage points of standards for PH	
8.5.2	**Expedited Service Authorization**				
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 3) TAT snapshot of the most recent quarter shows standards met	
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 3)	
8.5.3	**Post Authorization**				
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p.6) TAT snapshot of the most recent quarter shows performance within 4-5 percentage points for both PH and BH	
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 1)	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	or misrepresentation about the member's health condition made by the provider.				
8.5.4	**Timing of Notice**				
8.5.4.1	**Notice of Action**				
8.5.4.1.1	**Approval [Notice of Action]**				
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 3)	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 5)	
8.5.4.1.2	**Adverse [Notice of Action]**				
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.07 -Adverse Determinations (Denial) Decisions (p. 1) 10/10 files reviewed met all requirements regarding adverse determinations and notifications.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 4)	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.				
8.5.4.1.3	**Informal Reconsideration**				
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 6-7)	
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 7)	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 7)	
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.05 Timeliness of UM Decisions & Notifications (p. 7)	
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.12 Emergency and Post-Stabilization Services	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	out-of-network provider.				
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	1) UM Policy and Procedure	Full	Requirement addressed by: LA UM.01.01 - Covered Benefits & Services (p. 2)	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.01.01 - Covered Benefits & Services (p. 4)	
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.16 - Continuity and Coordination of Care (p. 2)	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.16 - Continuity and Coordination of Care (p. 3)	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.16.01 - Referrals to Specialty Health Care Services (p. 2-3)	
8.5.4.2	The MCO shall not require a PCP referral for in- network eye care and vision services.	1) UM Policy and Procedure 2) UM Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA UM.16.01 - Referrals to Specialty Health Care Services (p. 3) (PH and BH) LA UM.01.01 - Covered Benefits & Services (p. 4)	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	1) UM Policy and Procedure	Full	Requirement addressed by: LA UM.01.01 - Covered Benefits & Services (p. 2)	
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	1) UM Policy and Procedure	Full	Requirement addressed by: LA UM.01.01 - Covered Benefits & Services (p. 2)	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions	1) UM Policy and Procedure	Full	Requirement addressed by: LA UM.01.01 - Covered Benefits &	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	within one (1) business day of admission.			Services (p. 5)	
8.11	**Medical History Information**				
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.	1) UM Policy and Procedure	Full	Requirement addressed by: (PH) Clinical Information and Documentation (p. 1) (PH and BH) LA UM.01 - Medical Management Program Description (p. 10-11)	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	1) Other Documents	Full	Requirement addressed by: (PH and BH) LHC PPA Full Contract (p. 25, Section 3.41)	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	1) Other Documents	Full	Requirement addressed as cited at 8.11.2	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	1) Other Documents	Full	Requirement addressed as cited at 8.11.2	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**				
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	Provider Profile Reports	Full	Requirement addressed by: (PH) Provider Profile example (ABC Pediatrics) (BH) Cenpatico 2015 Program Evaluation (p. 7)	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	1) QI Policy and Procedure	Full	Requirement addressed by: (PH) LA QI.17 Monitoring Quality of Care (p. 1) (BH) Cenpatico 2015 Program Evaluation (p. 5)	
8.12.3	The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall include, but are not limited to, the following:	1) LDH Reports 2) LDH Reports	Full	Requirement addressed as cited at 8.12.1 for PH providers. On interview, the MCO notes BH providers do not have member	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				panels by which PMPM ED visits, hospital admissions, and ancillary utilization can be calculated. Other BH reporting includes compliance with evidence-based guidelines and fidelity standards. NOTE: As per 8.13.0 to follow, Report 72 PCP Profile Report 72 submission to DHH has been discontinued.	
8.12.3.1	Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	1) Provider Relations Policy and Procedure	Full	Requirement addressed by: LA.PRVR.24 Out of Network Referral Services (p. 1) (BH) N/A	
8.12.3.2	Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	1) Reports	Full	Requirement addressed by: Provider Profile example (ABC Pediatrics) (BH) N/A	
8.12.3.3	Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;	1) Reports	Full	Requirement addressed as cited at 8.12.3. Other BH reporting includes ED utilization by BH diagnosis, which is sent to PCP and CM.	
8.12.3.4	Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	1) QI Policy and Procedure	Full	Requirement addressed as cited at 8.12.3.	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	1) Sample Profile Report with HEDIS Measures	Full	Requirement addressed as cited at 8.12.3.	
8.13	**PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements**				
8.13.0	The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Report 72, Retired by State	Full	In agreement with other MCOs, Report 72 PCP Profile Report submission to DHH has been discontinued.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11	**Disenrollment**				
11.11.1	Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the Bayou Health Program.				
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 1	
11.11.3	**Member Initiated Disenrollment**				
11.11.3.1	A member may request disenrollment from a MCO as follows: For cause, at any time. The following circumstances are cause for disenrollment: •The MCO does not, because of moral or religious objections, cover the service the member seeks; •The member requests to be assigned to the same MCO as family members; •The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; •The contract between the MCO and DHH is terminated; •Poor quality of care; •Lack of access to MCO core benefits and services covered under the contract; •Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; •The member's active specialized behavioral health provider ceases to contract with the MCO; •Member moves out of the MCO's service area, i.e. out of state; or •Any other reason deemed to be valid by DHH and/or its agent.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 1 and 2	
11.11.3.2	Without cause for the following reasons:	Eligibility Policy and	Full	Addressed in LA.ELIG.02	

Eligibility, Enrollment and Disenrollment					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	•During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; •During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; •Once a year thereafter during the member's annual open enrollment period; •Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or •If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).	Procedure		Disenrollment Pg 2	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 1	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 3	
11.11.4	**MCO Initiated Disenrollment**				
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 3	
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 3	

Eligibility, Enrollment and Disenrollment					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.				
11.11.4.3	The following is the only allowable reason for which the MCO may request involuntary disenrollment of a member: the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH;	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 3	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pgs 3, 4, 5	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 3-4	
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 4	
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	Eligibility Policy and Procedure	Full	Addressed in LA.ELIG.02 Disenrollment Pg 4	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the				

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	member has a right to file an appeal directly through the State Fair Hearing process.				
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	Disenrollment	Full	Addressed in LA.ELIG.02 Disenrollment Pg 4	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**				
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):				
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: Flesch – Kincaid; Fry Readability Index; PROSE The Readability Analyst (software developed by Educational Activities, Inc.); Gunning FOG Index; McLaughlin SMOG Index; or other computer generated readability indices accepted by DHH.	1) Marketing Policy and Procedure 2) Newsletter - RGL	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 1) Member Handbook - Integrated (RGL) contains readability scores 2016 Q1 Member Newsletter - RGL contains readability scores	
12.9.2	All written materials must be clearly legible with a minimum font size of ten- point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.	1) Marketing Policy and Procedure 2) Member Handbook 3) Member Newsletter	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 1) Member Handbook - Integrated 2016 Q1-4 Member Newsletters	
12.9.3	DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.	1) Marketing Policy and Procedure 2) Member Handbook - RGL	Full	Requirement addressed as cited at 12.9.1	
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 1)	
12.9.5	All written materials must be in accordance with the DHH “Person First” Policy, Appendix NN.	1) Marketing Policy and Procedure 2) Member Handbook 3) Materials	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 1) Member Handbook - INTEGRATED Section Should You Be in Case Management? (p. 37) Health Outreach - Living Well with Sickle Cell Booklet (p. 2)	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 1)	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	MCO's commercial plans if applicable.				
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll- free number must be prominently displayed on the cover of all multi-paged marketing materials.	1) Marketing Policy and Procedure 2) Member Handbook - INTEGRATED.pdf 3) Materials	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 2) Although technically not marketing materials: Member Handbook - back cover New Member Welcome Newsletter - front cover	
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	1) Marketing Policy and Procedure 2) Materials New Member Welcome Newsletter	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 2) New Member Welcome Newsletter (p. 4)	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	1) Marketing Policy and Procedure 2) Member Handbook - INTEGRATED.pdf	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 2) Member Handbook (p. 25)	
12/9/10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.09 Written Materials Guidelines (p. 2)	
12.11	**Member Education – Required Materials and Services**				
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.11 Member Education Requirements (p. 1)	
12.11.3	**Member Materials and Programs for Current Enrollees**				
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general	1) Link to Member Portal/Resource Page/General Info 2) Link to interactive social Media Content	Full	Requirement addressed by: Member portal - http://www.LouisianaHealthConnect.com/For-Members Mobile app - http://www.louisianahealthconnect	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	3) Link to interactive social media content 4) Link to mobile device application		.com/2015/09/30/new-pregnancy-app/ Social media - https://www.facebook.com/louisianahealthconnect/ https://twitter.com/lahealthconnect	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	1) Materials	Full	Requirement addressed by: 2016 Q1-4 Member Newsletters	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	1) Materials	Full	Requirement addressed by: New Member Welcome Newsletter (p. 6-7, 19) Health Outreach -Well Child Check Up Birthday DM Health Outreach - AWC Reminder Letter Sample Health Outreach - ADHD Initiation	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	1) Materials	Full	Requirement addressed by: Health Outreach - Your Guide to a Healthy Pregnancy Health Outreach - Living Well with Sickle Cell Booklet Health Outreach - Sickle Cell Flyer	
12.11.3.5	Materials focused on health promotion programs available to the members;	1) Member Handbook 2) Materials	Full	Requirement addressed by: Member Handbook - Integrated Section Case Management (p. 37) 2016 Q2 Member Newsletter (p. 2)	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	1) Member Handbook 2) Materials	Full	Requirement addressed by: Member Handbook - Integrated Section Help Your Health (p. 33) 2016 Q1 Member Newsletter (p. 1)	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member Handbook - INTEGRATED.pdf 2) Materials	Full	Requirement addressed by: Member Handbook - Integrated Section Chronic Care Management (p. 39) Health Outreach - Bellies Babies Brunch Flyer On interview, the MCO described the Chronic Care Management program as a more personalized rather than classroom experience.	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				Members are connected to community resources and classes.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	1) Materials	Full	Requirement addressed by: Health Outreach - Living Well with Sickle Cell Booklet Health Outreach - Sickle Cell Flyer Health Outreach - HPV Vaccination Health Outreach - Mammograms	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	1) Materials	Full	Requirement as cited immediately above and: Health Outreach - Chlamydia Health Outreach - Provider HEDIS Guide	
12.11.3.11	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.11 Member Education Requirements (p. 5) Member Handbook - INTEGRATED (p. 5)	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	1) Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.11 Member Education Requirements (p. 5)	
12.12	**MCO Member Handbook**				
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (f)(6) for each of the covered populations as specified in section 3.3.3.)..	Member Handbooks (QTY 3)	Full	Requirement addressed by: Member Handbook - INTEGRATED Member Handbook - Mental Health and Substance Use (BH FACILITY) Member Handbook - Mental Health and Substance Use (BH NEMT) On interview, the MCO described the BH Facility and NEMT handbooks as varying by one benefit (added to NEMT).	
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:				
12.12.1.2	Table of contents;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 2-3)	
12.12.1.3	A general description about how MCOs operate, member rights and responsibilities, appropriate utilization of services including	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED - how MCOs operate (p. 8)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;			rights and responsibilities (p. 55-56) appropriate utilization (p. 43) PCP selection (p. 25) PCP role (p. 26)	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 57-58)	
12.12.1.5	Member's right to change providers within the MCO;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 25)	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 25)	
12.12.1.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 55-56)	
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED - benefits (p. 10-14) BH benefits (p. 10-13, 19) health education/promotion (p. 33-34, 39) tobacco cessation (p. 5, 17) problem gambling (p. 5)	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 41-42)	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 8)	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 23 & 44). In-network and out-of-network benefits described on page 25.	
12.12.1.12	The extent to which, and how, after- hours , crisis and emergency coverage are provided, including: •What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 44-55)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	•That prior authorization is not required for emergency services; •The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; •The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and •That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.				
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 45)	
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 19, 28)	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 24)	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 55)	
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	1) Member Handbook	N/A	Not Applicable-As there are no uncovered services of this type.	
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 51-52, 47-48)	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: •For State Fair Hearing: the right to a hearing; the method for obtaining a hearing; and the rules that govern representation at the	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED - state fair hearing (p. 49) file grievances (p. 51) timeframes (p. 47-49)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hearing; •The right to file grievances and appeals; •The requirements and timeframes for filing a grievance or appeal; •The availability of assistance in the filing process; •The toll-free numbers that the member can use to file a grievance or an appeal by phone; •The fact that, when requested by the member: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; •In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.			assistance (p. 48-50) toll-free numbers (p. 51, 48) continuation of benefits (p. 48) and DHH final authority (p. 49)	
12.12.1.20	Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of advance directives which shall include: •The MCO policies related to advance directives; •The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; •Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and · Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 40)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 57) Medicaid Self Service Portal http://new.dhh.louisiana.gov/index.cfm/page/237	
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a “no show”;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 26)	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 6)	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 30, 45)	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 15)	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman’s Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 54) Recommendation The handbook should state "immediately." **Post Onsite Plan Response:** Plan agrees and the verbiage change to the handbook has been proposed and is awaiting LDH approval before making the change on the website.	Plan staff agrees, appropriate verbiage change in process.
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 54)	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 8, 59)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;				
12.12.1.29	Instructions on how to request multi- lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 4)	
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 42)	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 53)	
12.12.1.32	Any additional text provided to the MCO by DHH or deemed essential by the MCO;	1) Member Handbook	N/A	Not Applicable-As all additional information noted in Handbook approved by LDH.	
12.12.1.33	The date of the last revision;	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 3 September 2016)	
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.6(h)]. Service utilization policies; and How to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED - MCO structure (p. 54 R/R) MD incentives (p. 54 R/R) utilization policies (p. 54 R/R) marketing violations (p. 52)	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: •A description of covered behavioral health services; •Where and how to access behavioral health services and behavioral health providers; •General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; •Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED - benefits (p. 19-20) access (p. 19-20) resilience (p. 21) family (p. 21) information sharing (p. 64-65) During the interview onsite, the MCO reported there is no age of consent for behavioral health treatment (therefore no documentation regarding the same).	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the strengths of individuals and families; and •Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.				
12.12.1.36	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	1) Other Documents-2016 Q3 Member Newsletter.pdf	Full	Requirement addressed by: 2016 Q3 Member Newsletter (p. 2)	
12.12.1.37	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members.	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 3 September 2016))	
12.14	**Provider Directory for Members**				
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	1) Marketing Policy and Procedure	Full	Requirement (hardcopy, hardcopy abbreviated, web-based searchable, weekly electronic file) addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 1)	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	1) Marketing Policy and Procedure 2) Provider Directory (Hard Copy)	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 1) Provider Directory Region 5.pdf	
12.14.1.2	Web-based, searchable, online directory for members and the public;	1) Marketing Policy and Procedure 2) Web Based Online Directory-Link	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 1) Find a Healthcare Provider https://providersearch.louisianahealthconnect.com/	
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and	1) Marketing Policy and Procedure 2) Electronic Update(s)	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 1) Provider Directory Electronic Update 20161109_2162845_PR.TXT Provider Directory Electronic Update 20161109_2162845_Site_PR.TXT	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	1) Marketing Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		2) Provider Directory - Abbreviated		Directory for Members (p. 1) Provider Directory - Abbreviated for Enrollment Broker.pdf	
12.14.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by DHH.	1) Marketing Policy and Procedure	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 1)	
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:				
12.14.4.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;	1) Marketing Policy and Procedure 2) Web Based Online Directory-Link 3) Electronic Update(s) 4) Provider Directory 5) Provider Directory - Abbreviated	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 2) Provider Directory Region 5.pdf Find a Healthcare Provider https://providersearch.louisianahealthconnect.com/	
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure	1) Marketing Policy and Procedure 2) Web Based Online Directory Link 3) Provider Directory 4) Provider Directory	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 2) Provider Directory Region 5.pdf Find a Healthcare Provider https://providersearch.louisianahealthconnect.com/ Regarding child serving lists, the MCO submitted a screenshot demonstrating use of the provider directory website to select BH	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;			services and the following specialties: Clinic/Center: Adolescent & Children Mental Health, Pediatrics: Developmental - Behavioral Pediatrics, Psychiatry: Child-Adolescent, Psychologist: School, Residential Treatment Facility.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	1) Marketing Policy and Procedure 2) Web Based Online Directory-Link 3) Electronic Update(s) 4) Provider Directory 5) Provider Directory - Abbreviated	Full	Requirement addressed as cited at 12.12.1.6 and by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 2) Provider Directory Region 5.pdf (p. 2)	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	1) Marketing Policy and Procedure 2) Web Based Online Directory-Link 3) Electronic Update(s) 4) Provider Directory 5) Provider Directory - Abbreviated	Full	Requirement addressed by: (PH and BH) LA.MRKT.14 Provider Directory for Members (p. 2) Provider Directory Region 5.pdf Find a Healthcare Provider https://providersearch.louisianahealthconnect.com/	
12.17.15	**Members' Rights and Responsibilities**				
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	1) Member Rights and Responsibilities Policy and Procedure	Full	Requirement addressed by: LA.MBRS.25 Member Rights and Responsibilities	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 55-56) (PH and BH) Provider Handbook (p.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				24-25)	
12.17.16	**Member Responsibilities**				
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 56)	
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: •Informing the MCO of the loss or theft of their ID card; •Presenting their MCO ID card when using health care services; •Being familiar with the MCO procedures to the best of the member's abilities; •Calling or contacting the MCO to obtain information and have questions answered; •Providing participating network providers with accurate and complete medical information; •Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; •Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; •Following the grievance process established by the MCO if they have a disagreement with a provider; and •Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care	1) Member Handbook	Full	Requirement addressed by: Member Handbook - INTEGRATED (p. 56)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	services, and contacting the provider in advance if unable to keep the appointment.				
12.18	**Notice to Members of Provider Termination**				
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.18 Notice to Members of Provider Termination (p. 1)	
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.18 Notice to Members of Provider Termination (p. 1)	
12.19	**Oral and Written Interpretation Services**				
12.19.1	In accordance with 42 CFR §438.10(b)(1) DHH shall provide on its website the prevalent non-English language spoken by enrollees in the state.				
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral	Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.19 Interpretation and Translation Services (p. 1)	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.				
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	Marketing Policy and Procedure	Full	Requirement addressed by: LA.MRKT.19 Interpretation and Translation Services (p. 1)	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**				
13.2	**General Grievance System Requirements**				
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents: LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process.	
13.2.2	**Filing Requirements**				
13.2.2.1	**Authority to File**				
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure 4) Other Documents>"Letters" Folder	Full	Evidence in support of this requirement was found in the policy documents: LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process, and LA.UM.08 Appeal of UM Decisions.	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents: LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process.	
13.2.3	**Time Limits for Filing** The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents: LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process.	
13.2.4 13.2.4.1	**Procedures for Filing** The member or provider may file an appeal either orally or in writing.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents: LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process, and LA.UM.08 Appeal of UM Decisions.	
13.2.4.2	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process	1) G& A Policy and Procedure	Full	Evidence in support of informing members about the appeals process	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	2) G& A Policy and Procedure 3) Provider Manual		was found on Page 47 of the Member Handbook; about the Grievance process on Page 51; and the State Fair Hearing rights/process on Page 49 of the Member Handbook.	
13.3	**Grievance/Appeal Records and Report**				
13.3.1	The MCO must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process.	
13.3.2	The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process. In addition, the meeting agenda for the CAC weekly review meetings indicates review of Clinical Appeals Coordinator caseloads and LDH Memos or updates. Several audit reviews and the sample appeal audit rollup sheet also provide evidence to support this requirement.	
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process. In addition, the meeting agenda for the CAC weekly review	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	grievance/appeal.			meetings indicates review of Clinical Appeals Coordinator caseloads and LDH Memos or updates. Several audit reviews and the sample appeal audit rollup sheet	
13.4	**Handling of Grievances and Appeals**				
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:				
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure 4) Other Documents>"Letters" Folder	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process. <u>Grievance File Review Findings:</u> 15 of 15 files reviewed met the requirement for acknowledgement of grievance receipt.	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process. Page 46 of the Member Handbook demonstrates communication of this requirement to the member.	
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process. <u>Grievance File Review Findings:</u> This requirement did not apply to 15 of the 15 files reviewed.	
13.4.2	**Special Requirements for Appeals** The process for appeals must:				
13.4.2.1	Provide that oral inquiries seeking to appeal	1) G& A Policy and Procedure	Full	Evidence in support of this	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.	2) UM Policy and Procedure 3) Other Documents>"Letters" Folder		requirement was found in the policy document LA.QI.11.03 Appeals Process.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	1) G& A Policy and Procedure	Substantial	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process; however, the sample Notice of Appeal Receipt does not communicate this requirement to the member. Nor does the Jane Doe Member Denial Letter address reasonable opportunity to present evidence. Recommendation: The plan should include with the Notice of Action and Appeal Acknowledgement letters an attachment that details this requirement (and each of the pertinent requirements not addressed in the body of each of these letters). **Plan response post onsite:** Plan provided templates of two changes made to the Notice of Disposition-Denial Letter, and the UM Denial Letter. Determination remains "Substantial."	The member is informed of his or her appeal rights with the UM letter, including the right to submit any other information for education and consideration prior to submitting the appeal. However, the recommendation to add this information to the acknowledgement letter is supported with action implemented to revise the Appeal Acknowledgement letter to "remind" and inform the member that he or she may also send in any other information in writing or by phone, which explains why we should pay for the service
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	1) G& A Policy and Procedure 2) Member Handbook	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process, and communicated to the member per the sample Notice of Appeal Receipt letter.	
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	estate.	2) Member Handbook		Process, and communicated to the member on Page 47 of the Member Handbook.	
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) Other Documents	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process, and implementation supported by GAC Meeting Agendas.	
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process.	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in §13.6 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy document LA.QI.11.03 Appeals Process, and is communicated to the member on Page 49 of the Member Handbook, as well as in the Jane Doe Member Denial letter.	
13.5	**Notice of Action**				
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and Section 12 of this RFP to ensure ease of understanding.	1) G& A Policy and Procedure 2) G& A Policy and Procedure 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found in the policy documents LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process.	
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:				
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.5.2.2	The reasons for the action;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.2.3	The member's right to file an appeal with the MCO;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.2.5	The procedures for exercising the rights specified in this section;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.2.6	The circumstances under which expedited resolution is available and how to request it;	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	This requirement is addressed in the LA.QI.11.03 Appeals Process policy and on Page 48 of the Member Handbook, as well as in the Jane Doe Member Denial Letter, and implemented in the Notice of Action letters reviewed on-site.	
13.5.2.8	Oral interpretation is available for all languages and how to access it.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the Jane Doe Member Denial Letter.	
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:				
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except:	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.1.1	The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following: •In the death of a recipient; •A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	information); •The recipient's admission to an institution where he is eligible for further services; •The recipient's address is unknown and mail directed to him has no forwarding address; •The recipient has been accepted for Medicaid services by another local jurisdiction; or •The recipient's physician prescribes the change in the level of medical care; or •As otherwise permitted under 42 CFR §431.213.				
13.5.3.2	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: •The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or •The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: •Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and •Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.5.3.3	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	expires. Untimely service authorizations constitute a denial and are thus adverse actions.	2) G& A Policy and Procedure		LA.QI.11.03 Appeals Process Policy document.	
13.5.3.6	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.7	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.5.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.				
13.6	**Resolution and Notification**				
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document and in the LA.QI.11.02 Grievance Process Policy Document.	
13.6.1	**Specific Timeframes**				
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document. <u>Grievance File Review Findings:</u> 15 of the 15 files reviewed met the 90 day timeliness standard.	
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.02 Grievance Process Policy document.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.				
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition** Grievances. The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in the LA.QI.11.02 Grievance Policy Process document and in the LA.QI.11.03 Appeals Process Policy document. <u>Grievance File Review Findings:</u> 15 of the 15 files reviewed met the requirement to send a resolution notice to the member. 12 of the 15 files met the requirement that the notice be provided in a manner and format that is easily understood. Although the language of each of the 15 resolution notices was easy to understand, member	Revision of letter to say: If your grievance concerns are related to a quality issue, a nurse or a Grievance and Appeal Department representative may call you for details related to your concerns. If you have any questions please call 1.866.595.8133

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				understanding of the underlying circumstances and additional opportunities to follow up on their concerns could be improved by addressing the following recommendations. Recommendations: For grievance cases referred to the Quality Department as a possible QOC issue (n=1), include in the resolution letter a statement to the effect that "A Quality Nurse will contact you to follow up on your concern/request regarding…" For grievances in which the member may be a candidate for CM (n=2), include in the letter a statement to the effect, "If you would like to follow up with Care Manager, please call…" **Post Onsite Plan Response:** Plan agreed with recommendation and provided the language to be incorporated into the letter revision. Determination remains unchanged.	
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document. **Recommendation** Onsite file review included review of 10 appeal files. Four (4) of the 10 files involved appeal approvals in favor of the members. The resolution letters included a description of the State Fair Hearing Option if the member disagreed, which could result in member confusion. It is recommended that a separate	State Fair Hearing verbiage to be removed from approval letter. Currently under revision.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				resolution letter for approval, without mention of the State Fair Hearing Option, be implemented. **Post Onsite Plan Response:** Plan agreed; State Fair Hearing verbiage to be removed from approval letter.	
13.6.5	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.				
13.6.5.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.6.5.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7	**Expedited Resolution of Appeals**				
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	1) G& A Policy and Procedure 2) Provider Manual	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: •Transfer the appeal to the timeframe for	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	standard resolution; •Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. •This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.				
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	1) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.8	**Continuation of Benefits**				
13.8.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.				
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: •The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; •The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; •The services were ordered by an authorized provider; •The original period covered by the original authorization has not expired; and •The member requests extension of benefits.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: •The member withdraws the appeal; •Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; •A State Fair Hearing Officer issues a hearing decision adverse to the member; •The time period or service limits of a previously authorized service has been met.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).				
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.02 Process Policy document, with communication to providers beginning on Page 125 of the Provider Manual. Recommendation: 1 of the 15 Grievance files reviewed entailed a complaint that the PCP "keeps prescribing high doses of ADHD medication and refusing referral to BH specialist." This practice is a barrier that presents an opportunity to develop an intervention/process to contact and educate specific PCPs regarding ADHD benefits, BH resources, and how to make referrals. The plan did discuss the possibility of incorporating into the Grievance process/system and the ADHD PIP an intervention to identify providers for education and BH referral facilitation. Post Onsite Plan Response: Plan's comment is that when the investigation of grievance validates the members' concerns, the Grievance and Appeals Department refers the grievance to Provider Relations to educate the provider on ADHD benefits. Behavioral Health resources, and how to make referrals. Case Management may	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				also assist with medication management.	
13.10	**Recordkeeping and Reporting Requirements**				
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.02 Grievance policy. Recommendation: At the on-site, the plan demonstrated implementation by sharing the snapshot of Sharepoint "DHH Narrative Explanation of Dissatisfaction," and the QOC Detail log, including the Detail Report of Trends by Category sent to DHH.	
13.11	**Effectuation of Reversed Appeal Resolutions**				
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	1) G& A Policy and Procedure 2) G& A Policy and Procedure	Full	Evidence in support of this requirement was found in LA.QI.11.03 Appeals Process Policy document.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**				
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:				
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	1) "QI Annual Work Plan 2016" 2) QAPI Program Description 3) 2015 Annual Evaluation 4) Quality of Care Policy and Procedure	Full	Evidence in support of this requirement was found on page 10 of the QAPI Program Description and in the QI Annual Work Plan 2016.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	1) "QI Annual Work Plan 2016" 2) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 37 of the QAPI Program Description, in the QI Annual Work Plan 2016 and in the Prematurity PIP baseline report.	
14.1.4	Detect and address underutilization and overutilization of services	1) "QI Annual Work Plan 2016" 2) QAPI Program Description 3) UM Policy and Procedure	Full	Evidence in support of this requirement was found on Page 21 of the LA.UM.01 Medical Management Program Description.	
14.1.5	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy	1) Quality Improvement Strategies 2) Provider Letter (PMUR) 3) Choosing Wisely Suggestions 4) QAPI Program Description	Full	The Quality Improvement strategies CPST PSR PMUR document addresses this requirement by including a psychotropic medication utilization program. In addition, on-site, the plan showed prior authorization examples, i.e., ADHD medication, T & A procedure, cardiac stress testing, and home oxygen.	
14.1.6	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant	1) "QI Annual Work Plan 2016"	Full	Evidence in support of this requirement was found in the baseline Prematurity PIP report.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	2) QAPI Program Description 3) Collaborative PIPs (ADHD) 4) Collaborative PIPs (Prematurity) 5) CM Policy and Procedure			
14.1.7	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	1) "QI Annual Work Plan 2016" 2) QAPI Program Description 3) Pharmacy Policy and Procedure	Full	Evidence in support of this requirement was found in the QI Annual Work Plan 2016 and in the policy LA.PMN.01 Appropriate Use and Safety Edits.	
14.1.8.	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	1) QAPI Program Description 2) Case Management Program Description 3) Predictive Modeling Policy and Procedure	Full	Evidence in support of this requirement was found in the QAPI Program Description on pages 4 and 23. On-site, the plan provided a definition of "special health care needs" in the CM Program Description LA.CM.01 document.	
14.1.9	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	1) Electronic Health Record Report 2) CMS Paid E.H.R Practitioner Report 3) Sample MRR tool showing one example of how E.H.R data is assessed.	Full	Evidence in support of this requirement was found in the EMR Report QTR 2 2016 and in the MRR Tool-HER Data Retrieval. On-site, the plan showed evidence of implementation, including: a fax blast on HER vendor & incentive fair, provider visit record to track EHR & CPG, screenshot of provider visit record; and explained how Provider consultants go out to provider offices, with 90% of providers visited per quarter.	
14.1.10	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the	1) QAPI Program Description 2) Population Assessment	Full	Evidence in support of this requirement was found in the 2015 CM NCQA Population Assessment, for the period from October 2014-September 2015.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.				
14.1.11	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Pages 10 , 27 and 28 of the QAPI Program Description, as well as in the Predictive Modeling Methodology policy/procedure LA.CM.06.	
14.1.12	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 6 of the QAPI Program Description and in the QI Work Plan 2016.	
14.1.14	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 10 of the QAPI Program Description.	
14.1.15	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	1) QAPIC Meeting Minutes showing provider participation/feedback, etc. 2) QAPIC Program Description	Full	Evidence in support of this requirement was found on Pages 17-18 of the QAPI Program Description, as well as in the Member Advisory Council Policy. The 2.26.2016 QAPIC Meeting Minutes addressed provider concerns, and member input via discussion of CAHPS and CM surveys, as well as grievances and appeals. On-site, the plan provided MAC meeting minutes (e.g., with 15 members in attendance) and a diagram that demonstrated how the MAC meeting findings are	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				relayed up to the QAPI and MAC minutes reported to DHH.	
14.1.16	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.	1) 2015 Annual Evaluation 2) Evidence of Submission of QAPI Evaluation	Full	Evidence in support of this requirement was found in the 2015 LHCC QAPO Annual EvalFinal 3.18.16, for the report period 1/1/15-12/31/15, with a screenshot of the ftp upload to support document submission.	
14.1.17	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	1) Clinical Practice Guideline Policy and Procedure 2) Other Documents	Full	Evidence in support of this requirement was found in LA.QI.08 Adopted Clinical Practice and preventive Health Guidelines.	-
14.1.18	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	QI Policy and Procedure	Full	Evidence in support of this requirement was found in the Peer Review Committee and Process policy. On-site, the plan provided Initials Files for Credentialing Committee Review 4/28/16.	
14/1/19	The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.	Collaborative PIP Meeting Minutes	Full	Evidence in support of this requirement was found in the LA PIP Meeting Minutes 3_17_16.	
14.1.20 14.1.20.1 14.1.20.2	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	1) BH Treatment Outcomes Report 2) Evidence of Submission of BH Treatment Outcomes report 320	Full	Evidence in support of this requirement was found in the 320 Behavioral Health Treatment Outcomes Report Q2 2016.	
	For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment,	1) BH Treatment Outcomes Report	Full	Evidence in support of this requirement was found in the 320 Behavioral Health Treatment Outcomes Report Q2 2016, with	

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	as well as the amount of improvement. In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual base.	2) Evidence of Submission of BH Treatment Outcomes report 321		documentation of submission via ftp site provided in a screenshot.	
14.2	**QAPI Committee**				
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:				
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QAPIC Charter 2016	Full	The QAPIC charter 2016 includes the Chief Medical Director on the Committee, and Page 11 of the QAPI Program Description states that the MCO Medical Director serves as the Chair or Co-chair.	
14.2.1.2	The MCO Behavioral Health Director;	QAPIC Charter 2016	Full	Evidence of this requirement was found in the QAPIC Charter 2016.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QAPIC Charter 2016	Full	Evidence of this requirement was found in the QAPIC Charter 2016.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPIC Charter 2016	Full	Evidence of this requirement was found in the QAPIC Charter 2016 and supported by the MAC Meeting Minutes, with 15 members in attendance, and by the Committee Structure diagram, as well as by the plan's explanation of how the MAC reports up to the QAPI.	
14.2.1.5	The MCO shall include DHH representative(s) on the QAPI Committee, as designated by DHH as non-voting member(s).	QAPIC Charter 2016	Full	Evidence of this requirement was found in the QAPIC Charter 2016, with implementation documented in the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPIC Charter 2016	Full	Evidence of this requirement was found in the QAPIC Charter 2016, with implementation documented in the 2.26.2016 QAPIC Meeting Minutes, which documented monthly meetings in January and February 2016.	
14.2.2.1	Direct and review quality improvement (QI) activities;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				LA.QI.01 QAPI Program Description on pages 10-17.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on pages 10-17, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.3	Review and suggest new and or improved QI activities;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on pages 10-17, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on pages 10-17, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.5	Designate evaluation and study design procedures;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on pages 10-17, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 22 of the QAPI Program Description, as well as in the Provider Profile Report.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on page 11, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on page 11, and further supported by the QI Annual Work Plan 2016.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				on page 12, and further supported by the 2.26.2016 QAPIC Meeting Minutes.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management services;	1) QAPI Program Description 2) 2015 Annual Evaluation	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description on page 23, and further supported by the 2015 LHCC QAPI Annual EvalFinal 3.18.16..	
14.2.2.11	Ensure that the QAPI committee chair attends DHH quality meetings; and	1) QAPI Program Description	Full	Page 12 of the QAPI Program description states that a representative of the QAPIC will attend LDH Quality Committee meetings on a regular basis. On-site, Dr. Marcus Wallace confirmed that he chairs the QAPI committee and attends DHH quality meetings.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Committee Charter	Full	The QAPIC charter states that the Committee objectives include recommending resources to support the on-going educational needs of providers relative to current managed care technologies. On-site, the plan shared documentation in support of updating provider manuals, e.g., QAPI Meeting minutes documents update discussion, with an update to the Provider Manual regarding Cultural Competency on Page 26.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	1) QAPI Work Plan 2) QI Documentation Cycle Policy and Procedure 3)Screenshot of IPRO Submission	Full	Evidence in support of this requirement was found in the QI Work Plan 2016, the LA.QI.01.02 Documentation Cycle, and the screenshot of the Work Plan-Report 121 Submission.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning,	1) QAPI Work Plan	Full	Evidence in support of this requirement was found in the QI	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	decision making, intervention and assessment of results;	2) QI Documentation Cycle Policy and Procedure		Work Plan 2016 and in the LA.QI.01.02 QI Documentation Cycle on Page 2. On site, the plan provided additional evidence, i.e., QAPI Annual Evaluation 3.18.16.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	1) QAPI Work Plan 2) QI Documentation Cycle Policy and Procedure	Full	Evidence in support of this requirement was found in the QI Work Plan 2016 and in the LA.QI.01.02 QI Documentation Cycle on Page 2. On site, the plan provided additional evidence, i.e., QAPI Annual Evaluation 3.18.16.	
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	1) QAPI Work Plan 2) QI Policy and Procedures	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	1) QAPI Program Description	Full	Evidence in support of this requirement was found in the LA.QI.01 QAPI Program Description, with general task assignments indicated in the QI Work Plan 2016.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	1) QAPI Work Plan 2) QI Documentation Cycle Policy and Procedure	Full	Evidence in support of this requirement was found on Page 17 of the LA.QI.01 QAPI Program Description by explicit statements of the "Louisiana Healthcare Connections" QAPI program.	
14.2.3.6	Describe the methods for ensuring data collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 4 of the LA QI.01 QAPI Program Description. On-site supporting evidence included: BH CPG Review Tool for ADHD, IRR Report Summary (nurse vs. Medical Director IS/SI InterQual criteria, Medical Record Review Appendix D-HEDIS-IRR Testing/Scoring.	
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each	1) Fidelity Monitoring Plan	Full	Evidence in support of this requirement was found in the	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	2) Email approving plan by LDH. 3) MOUs		document Fidelity to Evidence Based Practices Monitoring Plan 6.22.16 for Family Functional Therapy, Multisystemic Therapy , Homebuilders, and Assertive Community treatment.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Results of the evaluation of the impact and effectiveness of the QAPI program.	1) QAPI Program Description 2)Annual Evaluation	Full	Evidence of this requirement was found in the QAPI Program Description on page 23 and in the 2015 LHCC QAPI Annual EvalFinal 3.18.16.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.	1-5) BH Report(s)/Special Populations and evidence of submission 6) QAPI Program Description	Full	Evidence in support of this requirement was found in 313-Access to Wraparound MCO Q1, 329 Children served in restrictive settings Q2 2016, PASSR report q2 4 1 to 6 30.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the MCO Quality Companion Guide and the Behavioral Health Companion Guide.	1) QAPI Program Description 2) HEDIS IDSS Results 3) Non HEDIS Measures	Full	Evidence in support of this requirement was found on Page 23 of the QAPI Program Description, and in the IDSS Final Reported rates for MY 2015-RY 2016 and in the Healthy Louisiana Non-HEDIS Measures Report Submission 11 5 16.	
14.2.5.2	The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH	1) HEDIS IDSS Results 2) HEDIS Reporting Policy and Procedure	Full	Evidence in support of this requirement was found on Page 23 of the QAPI Program Description, and in the IDSS Final Reported rates for MY 2015-RY 2016 and in the Healthy Louisiana Non-HEDIS Measures Report Submission 11 5 16, as well as in the adult and child CAHPS reports.	
14.2.5.3	The MCO shall have processes in place to	1) HEDIS IDSS Results	Full	Evidence in support of this	

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	monitor and self-report all performance measures.	2) HEDIS Reporting Policy and Procedure 3) Attest Audit		requirement was found in the CC.QI.21 HEDIS Reporting CY 2016 policy/procedures document and in the Final Audit Report MY 2015, and in the IDSS Final Reported rates for MY 2015-RY 2016 and in the Healthy Louisiana Non-HEDIS Measures Report Submission 11 5 16, as well as in the HEDIS adult and CAHPS reports.	
14.2.5.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	IDSS Submission	Full	Evidence in support of this requirement was found in the IDSS Final Reported rates of MY 2015-RY 2016 and in the Healthy Louisiana Non-HEDIS Measures Report Submission 11 5 16.	
14.2.5.5	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	IDSS Submission	Full	Evidence in support of this requirement was found on Page 24 of the QAPI Program Description.	
14.2.5.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Pages 26-27 of the QAPI Program Description. In addition, the plan submitted the requested PM data pertinent to ADHD guidelines.	
14.2.5.7	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on pages 20-21 of the QAPI Program Description, and reported on PIP performance measures that required use of systems and performance monitoring tools.	
14.2.5.8	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on pages 20-21 of the QAPI Program Description, and reported on PIP performance measures that required use of systems and performance monitoring tools.	
14.2.5.9 14.2.5.9.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$".	1) HEDIS IDSS Results 2) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 30 of the QAPI Program Description, and in the IDSS Final Reported Rates	

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				for MY 2015-RY 2016	
14.2.5.9.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $2,225,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.				
14.2.5.10	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.	1) HEDIS IDSS Results 2) QAPI Program Description	Full	Evidence to support the plan's acknowledgement of this requirement was found on Page 1 of the QAPI Program Description.	
14.2.5.11 14.2.5.11.1	**Performance Measures Reporting** All measures contained in Appendix J MCO Performance Measures and the Behavioral Health Companion Guide are reporting measures.				
	14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH. 14.2.5.11.5 The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re- submissions. 14.2.5.11.6 The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.	1) HEDIS IDSS Results 2) QAPI Program Description	Full	Evidence to support this requirement was found on Pages 23-24 of the QAPI Program Description and in the IDSS final Reported Rates for MY 2015-RY 2016, as well as in the Final Audit Report MY 2015.	
14.2.5.12	**Performance Measure Goals** 14.2.5.12.1 The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the Bayou Health population.	QAPI Program Description	Full	The plan stated that LHC will actively participate with LDH to review the results of performance measures in comparison to established benchmarks, on page 24	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				of the QAPI Program Description.	
14.2.5.12.3	DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee. Final determination of goals is at the sole discretion and approval of DHH	QAPI Program Description	Full	The plan stated that LHC will collect and report clinical and administrative performance measures data in accordance with the Quality Companion Guide and MCO Behavioral Health Companion guide as published by LDH…and/or other measures as determined by LDH, on pages 23-24 of the QAPI Program Description.	
14.2.5.13	**Performance Measure Reporting** 14.2.5.13.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring. 14.2.5.13.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH. **Reporting Measures.** 14.2.5.13.4 The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting.	1) QAPI Program Description 2) Provider Profile Report	Full	The plan stated that LHC will collect and report clinical and administrative performance measures data in accordance with the Quality Companion Guide and MCO Behavioral Health Companion guide as published by LDH…and/or other measures as determined by LDH, on pages 23-24 of the QAPI Program Description. On-site, a provider profile report was provided.	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.240.	1) Collaborative PIPs (ADHD) 2) Collaborative PIPs (Prematurity) 3) QAPI Program Description	Full	Evidence was found in support of this requirement in the baseline Prematurity PIP document and the preliminary ADHD chart review findings submitted by the plan to IPRO.	
14.2.8.2	The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. DHH may require up to two (2) additional projects for a maximum of four (4) projects.	1) Collaborative PIPs (ADHD) 2) Collaborative PIPs (Prematurity) 3) QAPI Program Description	Full	Evidence was found in support of this requirement in the baseline Prematurity PIP document and the preliminary ADHD chart review findings submitted by the plan to IPRO.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.	1) Behavioral Health PIP 2) QAPI Program Description	Full	Evidence was found in support of this requirement in the preliminary ADHD chart review findings submitted by the plan to IPRO.	
14.2.8.3	Performance Improvement Projects shall be	1) Collaborative PIPs (ADHD)	Full	Evidence was found in support of	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: •Measurement of performance using objective quality indicators; •Implementation of system interventions to achieve improvement in quality; •Evaluation of the effectiveness of the interventions; and •Planning and initiation of activities for increasing or sustaining improvement.	2) Collaborative PIPs (Prematurity) 3) QAPI Program Description		this requirement in the baseline Prematurity PIP document and the preliminary ADHD chart review findings submitted by the plan to IPRO.	
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include: •An overview explaining how and why the project was selected, as well as its relevance to the MCO members and providers; •The study question; •The study population;•The quantifiable measures to be used, including the baseline and goal for improvement; •Baseline methodology; •Data sources; •Data collection methodology and plan; •Data collection plan and cycle, which must be at least monthly; •Results with quantifiable measures; •Analysis with time period and the measures covered; •Explanation of the methods to identify opportunities for improvement; and •An explanation of the initial interventions to be taken.	1) Collaborative PIPs (ADHD) 2) Collaborative PIPs (Prematurity) 3) QAPI Program Description	Full	Evidence was found in support of this requirement in the baseline Prematurity PIP document and on Page 30 of the QAPI Program Description.	
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: •Target specific conditions and specific health	1) Collaborative PIPs (ADHD) 2) Collaborative PIPs	Full	Evidence was found in support of this requirement in the baseline Prematurity PIP document and on Page 30 of the QAPI Program Description.	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; •Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; •Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; •Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; •Evaluate the effectiveness of the interventions; •Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; •Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; •Reflect the population served in terms of age groups, disease categories, and special risk status, •Ensure that multi-disciplinary teams will address system issues; •Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; •Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and •Maintain a system for tracking issues over time to ensure that actions for improvement are effective.	(Prematurity) 3) QAPI Program Description			
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	1) QAPI Program Description	Full	Evidence in support of this requirement was found on Page 32 of the QAPI Program Description and in the Adult and Child CAHPS reports.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	1) Vendor Contract	Full	Evidence in support of this requirement was found on Page 32 of the QAPI Program Description and in the Adult and Child CAHPS reports, as well as the Child CCC CAHPS Report.	
14.2.10.4	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS Reports (Adult, Child and Child w/ CCC Measurement Set	Full	Evidence in support of this requirement was found on Page 32 of the QAPI Program Description and in the Adult and Child CAHPS reports, as well as the Child CCC CAHPS Report.	
14.2.10.5	The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	CAHPS Reports (Adult, Child and Child w/ CCC Measurement Set	Full	Evidence in support of this requirement was found on Page 32 of the QAPI Program Description and in the Adult and Child CAHPS reports, as well as the Child CCC CAHPS Report.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	SPH Project Details Form	Full	Evidence in support of this requirement was found in the CAHPS Project Details Form-Signed 2.8.16.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS Reports (Adult, Child and Child w/ CCC Measurement Set	Full	Evidence in support of this requirement was found on Pages 5-8 of the Adult CAHPS survey, and Pages 5-7 of the Child CAHPS Survey.	
14.2.10.8	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Global Ratings.	CAHPS Reports (Adult, Child and Child w/ CCC Measurement Set	Full	Evidence in support of this requirement was found on Page 2 of the Adult CAHPS survey and the Child CAHPS Survey.	
14.2.10.9	The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.	351 Report Template(s)	Full	On-site, the plan shared instructions regarding the Adult and Child Template from LDH to begin reporting January 2017.	
14.4	**Health Plan Accreditation**				
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA	NCQA Accreditation Certificate	Full	Evidence in support of this requirement was found in the LHC-LA Final Letter NCQA Certificate.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	accreditation standards.				
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	Email Confirmation for confirmation of Application Submission and timeframes for reaccreditation process	Full	Evidence in support of this requirement was found in the email "FW NCQA HP ASSC Confirmation"; however, no documentation was found to specifically support DHH notification. On-site: The plan indicated they are waiting to hear from NCQA and will upload the relevant documents once received.	
14.4.3	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	NCQA Accreditation Certificate	N/A	Evidence in support of this requirement was found in the LHC-LA Final Letter NCQA Certificate, which showed that the plan received full accreditation status.	
14.5	**Member Advisory Council**				
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	1) Member Advisory Council P & P	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by the MAC meeting minutes.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	1) Member Advisory Council P & P	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by the MAC meeting minutes that showed the Director of Member and Provider Services as the chair.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	1) Member Advisory Council P & P	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by the MAC meeting minutes.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	1) Member Advisory Council P & P	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by the MAC meeting minutes.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter.	1) Member Advisory Council P & P	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by MAC meeting minutes and the MAC Plan submitted to DH.	
14.5.6.	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	1) Member Advisory Council 2) Marketing Policy and Procedure	Full	Evidence in support of this requirement was found in the policy LA.MBRS.05 Member Advisory Council, with implementation supported by MAC meeting minutes that were submitted to DHH.	
14.6	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Family Functional Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards are met. A formal fidelity-monitoring plan will be	1) Fidelity Monitoring Plan 2) Other Documents Email approving plan by LDH. 3) Other Documents MOUs	Full	Evidence in support of this requirement was found in the Fidelity Monitoring plan.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted to DHH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.				
14.8	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management. The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	1) AI Policy and Procedure 2) Other Documents Screen Shot of Submission 3) AI Report	Full	Evidence in support of this requirement was found in the policy LA.QI.31 Adverse Incidents, with a screenshot of Grievance/appeals reports uploaded to DHH, and the AIR was shared on site.	

Reporting					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
18.0	**Reporting**				
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	1) Other Documents 2) Other Documents 3a-e) Other documents-Multiple Screenshots	Full	Evidence in support of this requirement was found in the Corporate Centene MIS Data flow Narrative and the Corporate diagram, with supporting screenshots demonstrating implementation for LA Medicaid Managed Care enrollees. On-site, the MCO staff described how encounter, care management and grievance/appeals information systems are utilized to improve member care and integrate behavioral health with physical health care.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1	**General Requirements**				
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235.				
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	
15.1.3	The MCO shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.				
15.1.5	MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	
15.1.6	The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	
15.1.7	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3)	
15.1.8	The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3) LA.COMP.27 Ownership and Management Disclosure (p. 3-4) Disclosure of Ownership Form (p. 2)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	program to their designated Program Integrity contact.	3) Credentialing Policy and Procedure 4) Credentialing Policy and Procedure 5) Other Documents		Also addressed by: CC.CRED.01 Practitioner Credentialing and Recredentialing Attachment C (p. 6,)	
15.1.9	The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 2)	
15.1.10	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3) LA.COMP.27 Ownership and Management Disclosure Disclosure of Ownership Form (p. 1 change)	
15.1.11	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents 4) Other Documents 5) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3) LA.COMP.27 Ownership and Management Disclosure Disclosure of Ownership Form BECP Employee Attestation - electronic (Business Ethics and Conduct Policy)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.				
15.1.12	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3-4)	
15.1.13	The MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 4) See following requirements.	
15.1.13.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 4) See	
15.1.13.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 4)	
15.1.13.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 4)	
15.1.14	This prohibition described above in Section 15.1.13 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 4)	
15.1.15	The MCO shall comply with all federal and	1) Fraud Waste Abuse Policy	Full	Requirement addressed by:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.	and Procedure		LA.COMP 16 Fraud Waste Abuse Plan (p. 4)	
15.1.16	**Reporting and Investigating Suspected Fraud and Abuse**				
15.1.16.1	The MCO shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.				
15.1.16.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 5)	
15.1.16.3	The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when the concerns and/or allegations of any tips are authenticated.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 5-6)	
15.1.16.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to DHH and the appropriate agency as follows:	1) Fraud Waste Abuse Policy and Procedure 2) Reports	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6) 145 LHC 2016 Q2 and Q3 See following requirements.	
15.1.16.4.1	All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to DHH and MFCU;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.4.2	Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.4.4	All confirmed or suspected enrollee fraud and	1) Fraud Waste Abuse Policy	Full	Requirement addressed by:	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	abuse shall be reported immediately to DHH and local law enforcement.	and Procedure		LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.5	The MCO shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.6	The MCO shall be subject to a civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to DHH MFCU, as appropriate.				
15.1.16.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6-7) See following requirements.	
15.1.16.7.1	Contact the subject of the investigation about any matters related to the investigation;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 6)	
15.1.16.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7)	
15.1.16.8	The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7)	
15.1.16.9	The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.				
15.1.16.10	The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.		Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7)	
15.1.17	The State shall not transfer its law enforcement functions to the MCO.				
15.1.18	The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7)	
15.1.19	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	1) Fraud Waste Abuse Policy and Procedure 2) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 7) LHC PPA Full Contract (p. 6, 18)	
15.1.20	The MCO shall notify DHH when the MCO denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 8) CC.CRED.06 Ongoing Monitoring of	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	of providers to participate in the program for program integrity reasons.	Procedure 3) Credentialing Policy and Procedure 4) Other Documents 5) Other Documents		Sanctions & Complaints (p. 4 footnote 6, p. 9 Attachment C Louisiana Healthcare Connections Plan Unique Ongoing Monitoring Requirements) Provider Credentialing Packet (p. 9) Disclosure of Ownership Form (p. 2) and addressed by: CC.CRED.01 Practitioner Credentialing and Recredentialing Attachment C (p. 6, discovery at time of application, does not mention reporting to DHH as do other cited P/P)	
15.1.21	Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.				
15.1.22	In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the MCO shall report overpayments made by DHH to the MCO as well as overpayments made by the MCO to a provider and/or subcontractor.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 8)	
15.1.23	The MCO shall have at least one (1) full-time investigator or full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 3-4)	
15.2	**Fraud and Abuse Compliance Program**				
15.2.1	In accordance with 42 CFR §438.608(a), the MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 8) LA.COMP.100 Compliance and Ethics Program Description	
15.2.2	In accordance with 42 CFR §438.608(b)(2), the MCO shall designate a compliance officer and compliance committee that have the	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 8)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.	2) Other Documents 3) Other Documents 4) Other Documents		LHCC Program Integrity SIU Org Chart 2016 Q3 Part A LHCC Program Integrity SIU Org Chart 2016 Q3 Part B SIU Investigator Job Description	
15.2.3	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9) See following requirements.	
15.2.3.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9)	
15.2.3.2	Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9)	
15.2.3.3	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9) Report 145 2016 Q2 and Q3	
15.2.3.4	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9)	
15.2.3.5	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	accordance with 42 CFR §438.608(b)(4-6);			Plan (p. 9)	
15.2.3.6	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 9-10)	
15.2.3.7	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 10)	
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 10)	
15.2.3.9	Effective education for the Program Integrity Officer, program integrity investigators, managers, employees, providers and members to ensure that they know and understand the provisions of MCO's compliance plan;	1) Fraud Waste Abuse Policy and Procedure 2) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 10) SIU Investigators Sample Training Manual TFG	
15.2.3.10	Fraud, Waste and Abuse Training shall include, but not be limited to: •Annual training of all employees; •New hire training within thirty (30) days of beginning date of employment.	1) Fraud Waste Abuse Policy and Procedure 2) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 10) LHCC Compliance and HIPAA Training PowerPoint 2016 Centene Annual Compliance FWA Training Slides 2015	
15.2.3.11	MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: •MCO Code of Conduct Training •Privacy and Security – Health Insurance Portability and Accountability Act •Fraud, waste, and abuse •Procedures for timely consistent exchange of information and collaboration with DHH; •Organizational chart including the Program Integrity Officer and full-time program	1) Fraud Waste Abuse Policy and Procedure 2) Other Documents 3) Other Documents 4) Other Documents 5) Other Documents 6) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 10) LHCC Compliance and HIPAA Training PowerPoint 2016 Centene Annual Compliance FWA Training Slides 2015 and addressed by: Centene Employee Handbook (p. 13) Handbook Acknowledgement	

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	integrity investigator(s); and •Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.	7) Other Documents 8) Other Documents		Centene Business Ethics and Conduct Policy Centene 101 Compliance video Centene 101 HIPAA video Centene 101 Billing Errors Abuse and Fraud video HIPAA and Compliance Tips Sheet	
15.3	**Prohibited Affiliations**				
15.3.1	In accordance with 42 CFR 438.610, the MCO is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.				
15.3.2	The MCO shall comply with all applicable provisions of 42 CFR 438.610 pertaining to debarment and/or suspension. The MCO shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Compliance Policy and Procedure 4) Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 11) CC.COMP.36 Employee and Vendor Exclusion Screening CC.COMP.35 Disclosure of Ownership and Control Forms Exclusion Screening (Exclusion Vendor OIG Compliance Now) CC.CRED.01 Practitioner Credentialing and Recredentialing (p. 16)	
15.3.3	The MCO shall search the following websites: •Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); •Louisiana Adverse Actions List Search; •The System of Award Management (SAM); and •Other applicable sites as may be determined by DHH	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Compliance Policy and Procedure 4)Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 11) CC.COMP.36 Employee and Vendor Exclusion Screening (p. 5) CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints (p. 2-3, 9 Attachment C Louisiana Healthcare Connections Plan Unique Ongoing Monitoring Requirements)	

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		5) Credentialing Policy and Procedure			
15.3.4	The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Compliance Policy and Procedure 4) Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 11) and addressed by: LA.COMP.27 Ownership and Management Disclosure (p. 4 reporting within 3 days) CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints (p. 3-4 monthly monitoring, p. 5 shall not be reimbursed)	
15.3.4.1	An individual who is an affiliate of a person described above include: •A director, officer, or partner of the MCO; •A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or •A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 11) and addressed by: LA.COMP.27 Ownership and Management Disclosure (p. 2-3 ownership)	
15.3.4.2	The MCO shall notify DHH within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 12)	

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	which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.				
15.4	**Payments to Excluded Providers**				
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services ; and	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 12)	
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 12)	
15.5	**Reporting**				
15.5.1	In accordance with 42 CFR 455.1(a)(1) and 455.17, the MCO shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 12)	
15.5.2	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:				
15.5.2.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (defined at 42 CFR 455.14);	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13)	
15.5.2.2	Number of complaints reported to the Program Integrity Officer; and	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13)	
15.5.2.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse	

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	455.16, the MCO shall provide DHH, at a minimum, the following: •Provider name and ID number; •Source of complaint; •Type of complaint; •Nature of complaint; •Approximate range of dollars involved if applicable; and •Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.			Plan (p. 13)	
15.5.3	The MCO, through its compliance officer, shall attest to DHH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	1) Fraud Waste Abuse Policy and Procedure 2) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) July 2016 Program Integrity Attestation Letter	
15.6	**Medical Records**				
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure 3) Other Documents 4) Provider Manual	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 1-2) LHC PPA Full Contract (p. 7) Provider Manual (p. 71) See following requirements.	
15.6.1.1	Accurate and legible;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 1, Attachment A Medical and Treatment Record Review Tool - PH and BH, p. 14-15 Attachment C Medical Records Documentation Standards)	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 15)	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 1)	

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15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 1) See following requirements.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 14) See following requirements.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 13) LA.QI.13 Medical Record Review (p. 14) See following requirements.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14)	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14, although history required for patient seen 3 or more times) During the onsite interview, FWA and Clinical personnel described audit and look-back for medical history for all members, despite time of enrollment. Clinical personnel further direct providers to retain medical history when charts are thinned, and re-sign the history each year.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14)	
15.6.2.6	Documentation of emergency and/or after-	1) Fraud Waste Abuse Policy	Full	Requirement addressed by:	

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	hours encounters and follow-up;	and Procedure 2) QI Policy and Procedure		LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14)	
15.6.2.7	Signed and dated consent forms (as applicable);	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 15)	
15.6.2.8	Documentation of immunization status;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14)	
15.6.2.9	Documentation of advance directives, as appropriate;	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 15)	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 1, 14)	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 14)	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 14) LA.QI.13 Medical Record Review (p. 1)	

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		3) Member Handbook 4) Provider Handbook		Member Handbook (p. 55 Member Rights) Provider Handbook (p. 24 Member Rights)	
15.6.4	All documentation and/or records maintained by the MCO or any and all of its network providers shall be maintained for at least six (6) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	1) Fraud Waste Abuse Policy and Procedure 2) QI Policy and Procedure 3) Provider Manual 4) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15) LA.QI.13 Medical Record Review (p. 1) Provider Handbook (p. 71) LHC PPA Full Contract (p. 24)	
15.7	**Rights of Review and Recovery by MCO and DHH**				
15.7.1	Each MCO is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the MCO subcontracts to outside entities.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15)	
15.7.2	The MCO has the exclusive right of review and recovery for twelve 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment by delivering such notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15)	
15.7.3	All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15)	

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	Department. This review period is inclusive of all provider notification, health plan document review, and including any provider appeal or rebuttal process. The MCO shall notify the Department, at least on a monthly basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.				
15.7.4	The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15)	
15.7.5	If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim review recovery after 365 days from the date of notice to the Department of the collection status, unless in either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 15-16)	
15.7.6	The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of an improper payment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
15.7.7	DHH may recover from the provider any	1) Fraud Waste Abuse Policy	Full	Requirement addressed by:	

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	overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.	and Procedure		LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
15.7.8	DHH must notify the MCO of an identified improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payment(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
15.7.9	The MCO shall not correct claims not initiate an audit on the claims upon notification by the Department or its agent unless directed to do so by the Department.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
15.7.10	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department of its agent will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund any amounts collected to the Department. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
15.7.11	There will be no DHH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Bayou Health Contract period of for providers for which no MCO relationship existed.	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
	Additional PE-Related RFP Sections				
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17) CC.CRED.01 Practitioner Credentialing and Recredentialing	

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	activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.	3) Compliance Policy and Procedure 4) Credentialing Policy and Procedure 5) Credentialing Policy and Procedure 6) Credentialing Policy and Procedure		(p. 1) C.CRED.06 Ongoing Monitoring of Sanctions & Complaints (p. 1) CC.CRED.07 Practitioner Disciplinary Action and Reporting (p. 3) and addressed by: CC.COMP.36 Monthly Employee Board Member and Vendor Exclusion Screening Process (screening) CC.COMP.35 Disclosure of Ownership and Control Forms Exclusion Screening (screening)	
4.1.4	The MCO shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17)	
7.6.2	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	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure 3) Compliance Policy and Procedure	Full	Requirement addressed as cited at 4.1.2 and: LHC PPA Full Contract (p. 9 immediate termination)	

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	programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.	4) Credentialing Policy and Procedure 5) Credentialing Policy and Procedure 6) Credentialing Policy and Procedure 7) Other Documents 8) Other Documents			
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.	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure 3) Compliance Policy and Procedure 4) Credentialing Policy and Procedure 5) Credentialing Policy and Procedure 6) Credentialing Policy and Procedure 7) Other Documents 8) Other Documents	Full	Requirement addressed as cited at 4.1.2 and: LHC PPA Full Contract (p. 9 immediate termination)	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure 6) Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 17-18) LHC PPA Full Contract (p. 30 shall not pay claim)	

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17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure 3) Credentialing Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 18) CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints (p. 1) CC.CRED.07 Practitioner Disciplinary Action and Reporting (p. 3)	
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 18) LA.COMP.27 Ownership and Management Disclosure (p. 1) Disclosure of Ownership Form	
18.2	Information Related to Business Transactions - 18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 18) LA.COMP.27 Ownership and Management Disclosure (p. 4) Disclosure of Ownership Form	

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Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.				
18.3	Report of Transactions with Parties in Interest – 18.3.1 The MCO shall report to DHH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest. 18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents 4) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 19) Provider Credentialing Packet	
18.7	The MCO shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	1) Fraud Waste Abuse Policy and Procedure 2) Compliance Policy and Procedure 3) Other Documents	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 19) LA.COMP.27 Ownership and Management Disclosure (p. 3-4) Provider Credentialing Packet	
25.13.1	Debarment, Suspension, Exclusion - 25.13.1 The MCO agrees to comply with all applicable	1) Fraud Waste Abuse Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp; the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.dhh.la.gov/; and/or the System for Award Management, http://www.sam.gov . 25.13.2 The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act	2) Compliance Policy and Procedure 3)Compliance Policy and Procedure 4) Credentialing Policy and Procedure 5) Credentialing Policy and Procedure		Plan (p. 19) CC.CRED.01 Practitioner Credentialing and Recredentialing (p. 1) CC.COMP.35 Disclosure of Ownership and Control Forms Exclusion Screening	

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Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and 42 CFR §1003.102(a)(2).				
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual; Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.	1) Fraud Waste Abuse Policy and Procedure 2) Credentialing Policy and Procedure 3) UM Policy and Procedure	Full	Requirement addressed by: LA.COMP 16 Fraud Waste Abuse Plan (p. 20) CC.UM.18 Transplant Service Authorizations	