Readiness Review Submission Form - 7.0 Provider Network Requirements MCO: Louisiana Healthcare Connections

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.1	**General Provider Network Requirements**				
7.1.1	The MCO must maintain a network that ensures, at a minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Met This requirement is addressed in the Network Development and Management Plan, the Network Adequacy Policy and Procedure and the Network Development and Management Provider Appointment Accessibility documentation provided.	Network Development & Management Plan Network Adequacy Network Development & Management Provider Appt Accessibility	LA.CONT.01 LA.CONT.05 LA.PRVR.04	Covered throughout documents
7.1.2	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Met This requirement is addressed in the Network Development and Management Plan, the Network Adequacy Policy and Procedure and the Network Development and Management Provider Appointment Accessibility documentation provided.	Network Development & Management Plan Network Adequacy Network Dev/Mgt Provider Appt Accessibility	LA.CONT.01 LA.CONT.05 LA.PRVR.04	Covered throughout documents
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.	Met This requirement is addressed in the Network Development and Management Plan, the Network Adequacy Policy and Procedure and the Network Development and Management Provider Appointment Accessibility documentation provided. LHCC Readiness Review Response Appt Availability document provides a summary of data to demonstrate the plan's ability to produce availability data. LA PRVR 04 was adjusted to capture the contract period requirements.	Network Development & Management Plan Network Adequacy Provider Appt Accessibility Network Dev/Mgt	LA.CONT.01 LA.PRVR.04 LA.CONT.05	Covered throughout documents
7.1.4	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Met This requirement is addressed on page 7 of the Network Adequacy Policy and Procedure under Section XIII 'Out-of-Network Services'.	Network Adequacy	LA.CONT.01	7
7.1.5	The MCO's network providers shall comply with all requirements set forth in this RFP.	Met This requirement is addressed in the Louisiana Coordinated Care Network contract submitted as Product Attachment A.	Product Attachment A		1

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7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206(c)(2).	Met This requirement is addressed in the Provider Services Manual on page 18 – Cultural Competency.	/10 Provider Services/Provider_Manual.docx	Cultural Competency	18
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:	Met The contract requirements are addressed in the Provider Accessibility Standards. The Provider Manual also addresses the requirement.	Provider Appointment Accessibility Standards	LA.PRVR.04	1-2
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Accessibility Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.2	Urgent Care within twenty-four (24) hours; Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements.	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards. This requirement is also addressed on pages 1 and 2 of the Provider Appointment Accessibility Standards documentation.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.3	Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14

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7.2.1.4	Routine, non-urgent, or preventative care visits within six (6) weeks;	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes apply for existing ember or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within fourteen (14) days; within the second trimester within seven (7) days; within their third trimester within three (3) days; high risk pregnancies within three (3) days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	Met This requirement is addressed in the Provider Services Manual on page 14 under Appointment Availability Standards. This requirement is also addressed on pages 1 and 2 of the Provider Appointment Accessibility Standards documentation.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.2.1.8	Follow-up visits to ED visits in accordance with ED attending provider discharge instructions.	Met This requirement is addressed in the Provider Appointment Availability Standards on pages 1 and 2 as well as in the Provider Manual (see pages 13-14).	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14

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7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room: If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.; Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures; Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	Met This requirement is addressed in the Provider Appointment Availability Standards on pages 1 and 2 as well as in the Provider Manual (see pages 13-14).	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	1-2 14
7.3	**Geographic Access Requirements**				
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as determined by DHH approved mapping software (*e.g.* GeoAccess). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	Met This requirement is addressed throughout the Network Adequacy Policy and Procedure.	Network Adequacy Network Development & Management Plan GeoAccess Reports	LA.CONT.01	Covered throughout documents
7.3.1 7.3.1.1 7.3.1.2	**Primary Care Providers** • Travel distance for members living in rural parishes shall not exceed 30 miles; and • Travel distance for members living in urban parishes shall not exceed 10 miles (Appendix UU states 20 miles)	Met This requirement is addressed on page 3 through 5 of the Network Adequacy Policy and Procedure. Geo Access Report Deficiencies were found regarding member access to PCPs within 30m in rural parishes and 10m in urban parishes. The Plan submitted PCP Map and Network Gap Explanation, G 1 A Attachment RFP Appendix FF 09222014 FINAL, and Correction Actions indicating status as of 2/24/15 and on-going plans to address deficiencies.	Network Adequacy Network Development & Management Plan GeoAccess Reports	LA.CONT.01	3 4-5

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7.3.2 7.3.2.1 7.3.2.2	**Acute Inpatient Hospitals** • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	Met This requirement is addressed on pages 6 and 7 of the Network Adequacy Policy and Procedure. Geo Access Report Deficiencies were found regarding member access to Acute Care Hospitals within 30m in rural parishes and 10m in urban parishes. The Plan submitted General Acute Hospital Map and Network Gap Explanation, G 1 A Attachment RFP Appendix FF, and Correction Actions indicating status as of 2/24/15 and on-going plans to address deficiencies.	Network Adequacy Network Development & Management Plan	LA.CONT.01	6 7
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	**Specialists** • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT **– Network Providers by Specialty Type.** DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	Met This requirement is addressed on pages 3 and 4 of the Network Adequacy Policy and Procedure as well as on pages 5 and 6 of the Network Development and Management Plan. Geo Access Reports Deficiencies were noted in **Adolescent Medicine** **Cardiac Electrophysiology** **Clinic or Other Group Practice** **Critical Care Medicine** **Diagnostic Labs** **Endocrinology and Metabolism** **Geriatric Medicine** **Gynecological Oncology** **Hand Surgery** **Maternal and Fetal Medicine** **Nuclear Medicine** **All Specialty Pediatric Areas** **Proctology** **Surgery Critical Care** **Rural Health Clinics**	Network Adequacy Network Development & Management Plan	LA.CONT.01	3-4 5-6

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		The Plan submitted Updated Tables for G1-ND edits indicating gaps and interventions in the following specialty areas: Adolescent Medicine Cardiac Electrophysiology Critical Care Medicine Endocrinology and Metabolism Geriatric Medicine Gynecologic/Oncology Hand Surgery Maternal and Fetal Medicine Nuclear Medicine Pediatric Specialty Areas Proctology Surgery Critical Care Also Explanation of Network Gaps and Plans to Redress Deficiencies addresses Specialist and Network Deficiencies Contract Log 091814 indicates outreach/contact with deficient specialty providers.			
7.3.4 7.3.4.1 7.3.4.2	**Lab and Radiology Services** • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Met This requirement is addressed on pages 5 and 7 of the Network Adequacy Policy and Procedure. Geo Access Reports Deficiencies were found in the area of Lab Services. Lab X Ray Map and Explanation of Network Gaps and Plans to Redress Deficiencies submitted indicating status as of 2/24/15 and on-going plans to address deficiencies.	Network Adequacy Network Development & Management Plan	LA.CONT.01	5 7

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7.3.5 7.3.5.1 7.3.5.2	**Pharmacies** • Travel distance shall not exceed 10 miles in urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	Met This requirement is addressed on page 7 of the Network Adequacy Policy and Procedure. Geo Access Reports Deficiencies were found in pharmacies within 10m within urban parishes. Plan submitted Pharmacy Map dated 2/20/15 indicating current status. Also submitted Deficient County Outreach log.	Network Adequacy Network Development & Management Plan	LA.CONT.01	7 7
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.	Met This requirement is addressed on page 7 of the Network Adequacy Policy and Procedure. Geo Access Reports Deficiencies were found in hemodialysis centers in both urban and rural areas. Plan submitted Explanation of Network Gaps and Plans to Redress Deficiencies.	Network Adequacy Network Development & Management Plan	LA.CONT.01	7
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in Appendix UU.	Not Met Information pertaining to ratio requirements of providers to members is addressed on page 3 of the Network Adequacy Policy and Procedure. Deficiencies were observed in the geo access reporting thereby rendering that the network has an insufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Plan submitted Member Ratio Capacity Report for 4/1/ - 6/30/2014. It is not clear that this represents/indicates the plan's analysis and CAP.	Network Adequacy	LA.CONT.01	3
7.5	**Monitoring and Reporting on Provider Networks**				

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7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the /10 Provider Services/Provider_Manual.docx. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Met This requirement is addressed on page 14 of the Provider Manual as well as in the Provider Appointment Accessibility Standards.	Provider Appointment Accessibility Standards /10 Provider Services/Provider_Manual.docx	LA.PRVR.04 Appointment Accessibility Standards	Covered throughout policy 14
7.6	**Provider Enrollment**				
7.6.1 7.6.1.1	**Provider Participation -** The MCO must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs); all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); the MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services).	Met This requirement is addressed on pages 3 and 4 of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	3-4
7.6.1.2	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Met This requirement is addressed on page 8 (sub section 7) of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	2
7.6.1.3	If a current Medicaid provider requests participation in a MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Met This requirement is addressed on page 8 (sub section 7) of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	8

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7.6.1.4	The provision in Section (7.6.1.2 and 7.6.1.3) does not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Met This requirement is addressed on pages 4 through 7 of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	4-5, 7
7.6.1.5	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Met This requirement is addressed on pages 4 and 5 of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	4-5
7.6.2 7.6.2.1	**Exclusion from Participation -** The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdbhipdb. hrsa.gov/index.jsp.	Met This requirement is addressed in the Practitioner Credentialing and Recredentialing documentation provided.	CC.CRED.01	Practitioner Credentialing & Recredentilaing	1, 6, 14, 25, 31, 43
7.6.3 7.6.3.1	**Other Enrollment and Disenrollment Requirements -** The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Met This requirement is addressed on page 2 of the Network Selection and Retention Policy and Procedure. This requirement is also addressed in the plan's Network Development and Management Plan on page 2.	Network Selection & Retention Network Development & Management Plan	LA.CONT.02	2 2
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities	Met This requirement is addressed on page 2 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	2

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7.6.3.3	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider. The MCO shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.	Met This requirement is addressed on page 2 of the Provider Termination Policy and Procedure.	Provider Termination	LA.CONT.23	2
7.6.3.4	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	Met This requirement is addressed on page 1 of the Member Advisory of Provider Termination P/P.	Member Advisory of Provider Termination	LA.MBRS.27	1
7.7	**Mainstreaming**				
7.7.1	DHH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Met This requirement is addressed on pages 13 and 14 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	Mainstreaming	13-14
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Met This requirement is addressed on pages 13 and 14 of the Provider Manual. The plan demonstrates that it takes affirmative action to provide covered services without regard to a protected class in the Provider Manual and in provider training materials.	/10 Provider Services/Provider_Manual.docx	Mainstreaming	13-14
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Met This requirement is addressed on pages 13 and 14 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	Mainstreaming	13-14
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Met This requirement is addressed on pages 13 and 14 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	Mainstreaming	13-14
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Met This requirement is addressed on pages 13 and 14 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	Mainstreaming	13-14
7.8	**Primary Care**				

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7.8.0	The PCP shall serve as the member's initial and most important point of interaction with the MCO's provider network. A PCP in the MCO must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.	Met This requirement is addressed in the Provider Manual. PCP responsibilities are delineated on page 12 of the Provider Manual. The requirement is communicated to the members through the Member Handbook at pages 26 and 27.	/10 Provider Services/Provider_Manual.docx /12.0B Member Education/Member Handbook.docx	PCP Responsibilities	12 Member Handbook pg 26 & 27
7.8.1	**Assignment of Primary Care Providers**				
7.8.1.1	As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of MCO.				
7.8.1.2	If the choice of MCO and PCP is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of MCO and if available the PCP of choice.				
7.8.1.3	The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a MCO.				
7.8.1.4	The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to MCO.	Met This requirement is addressed on page 1 of the PCP Auto-Assignment P/P.	This is a requirement of the Enrollment Broker; however, the attached “PCP Auto Assignment” document identifies what happens when a member does not self-select a PCP at the time of enrollment.	LA.ELIG.04	Pg 2
7.8.1.5	The MCO shall confirm the PCP selection information in a written notice to the member.	Met This requirement is addressed on page 3 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	Pg 3
7.8.1.6	If no PCP is selected on the Member File received from the Enrollment Broker, the MCO shall contact the member, as part of the welcome call, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP or auto assign a PCP;	Met This requirement is addressed on page 2 of the PCP Auto Assignment P/P. The requirement that the member be contacted within 10 business days is describe within the New Member Welcome Calls P/P on page 1.	PCP Auto Assignment New Member Welcome Calls	LA.ELIG.04 LA.CM.01.04	Pg 2 Pg 1
7.8.1.7	Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members,	Met This requirement is addressed on page 26 of the Member Handbook whereby members are advised	12.0B Member Education/Member Handbook.docx		26

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	as appropriate.	of their right to choose their PCP.			
7.8.1.8	Members, for whom an MCO is the primary payor, who do not proactively choose a PCP will be auto-assigned to a PCP by the MCO. Members, for whom an MCO is a secondary payor, will not be assigned to a PCP by the MCO, unless the members request that the MCO do so.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	Pg 1
7.8.1.9	The MCO shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.	Met This requirement is addressed on page 2 of the PCP Selection and Change P/P. *Maximus* is named in the P/P as the EB.	PCP Selection & Change	LA.ELIG.03	2
7.8.1.10	If the member does not select a PCP and is auto assigned to a PCP by the MCO, the MCO shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P. This requirement is addressed also in the Member Handbook under the Section 'Choosing a PCP' on page 24.	PCP Auto Assignment /12.0B Member Education/Member Handbook.docx	LA.ELIG.04 Choosing a PCP	Pg 2&3 24
7.8.1.11	Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12) months beginning from the original date the member was assigned to the MCO.	NA The plan does not have a lock in assignment for selection of PCPs. The member can change PCP at any time without cause or penalty.	NA Members can change at any time, no lock-in	LA.ELIG.04	Pg 2 & 3
7.8.1.12	If a member requests to change his or her PCP with cause, at any time during the enrollment period, the MCO must agree to grant the request.	Met This requirement is addressed on page 3 of the PCP Auto Assignment P/P. This requirement is communicated to the member in the New Member Welcome Call materials.	PCP Auto Assignment New Member Welcome Call	LA.ELIG..04 LA.CM.01.04	Pg 3

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7.8.1.13	The MCO shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The MCO shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP.	Met This requirement is addressed within the PCP Auto Assignment P/P, the Member Advisory of Provider Termination P/P as well as in the Termination Notice Notification documentation.	PCP Auto assignment Member Advisory of Provider Termination Term Notice Notification.	LA.ELIG.04 LA.MBRS.27 LA.MBRS.27 Attachment A	1 Pg 2 and 3
7.8.1.14	The MCO shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the MCO signs the Contract with DHH.	Met This requirement is addressed on page 1 of the Network Adequacy P/P.	As an incumbent plan, we have an extensive network in place and are paying claims and supporting members/providers through our call centers, and we have the capacity to continue to do so during the transition period into the new contract.		See note in previous column
7.8.1.15	The MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination.	Met This requirement is addressed on page 2 of the Provider Termination P/P.	Provider Termination	LA.CONT.23	2
7.8.1.16	The MCO shall have written policies and procedures for handling the assignment of its members to a PCP. The MCO is responsible for linking to a PCP all assigned MCO members for whom the MCO is the primary payor.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	Pg 1
7.8.1.17	**PCP Auto-Assignments**				
7.8.1.17.1	The MCO is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign to a PCP an enrollee for whom the MCO is the primary payor when the enrollee:	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.2	Does not make a PCP selection after a voluntary selection of a MCO; or	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.3	Selects a PCP within the MCO that has reached their maximum physician/patient ratio; or	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.4	Selects a PCP within the MCO that has restrictions/limitations (e.g. pediatric only practice).	Met This requirement is addressed on page 1 of the	PCP Auto Assignment	LA.ELIG.04	1

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		PCP Auto Assignment P/P.			
7.8.1.17.5	Does not make a selection of a PCP for a newborn within fourteen (14) calendar days of birth. The effective date of a PCP selection or assignment of a newborn will be no later than the first month of enrollment subsequent to the birth of the child.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.6	Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the MCO plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.7	If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P.	PCP Auto Assignment	LA.ELIG.04	1
7.8.1.17.8	The final MCO and PCP automatic assignment methodology must be provided thirty (30) days from the date the MCO signs the contract with DHH. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the MCO's website, Provider Handbook, and Member Handbook.	Met This requirement is addressed on page 1 of the PCP Auto Assignment P/P. This requirement is communicated to the providers in the Provider Manual on page 11.	PCP Auto Assignment /10 Provider Services/Provider_Manual.docx	LA.ELIG.04 Assignment to Medical Home	1 11
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 the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12

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7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients.	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	Met This requirement is addressed on page 50 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	Provider Responsibilities	50
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	Met This requirement is addressed on page 15 of the Provider Manual under subsection '24 Hour Access'.	/10 Provider Services/Provider_Manual.docx	24 Hour Access	15
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Met This requirement is addressed on page 12 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx	PCP Responsibilities	12
7.8.3	**Specialty Providers**				
7.8.3.1	The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.				
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	Met This requirement is addressed on page 1 of the Network Adequacy Policy and Procedure.	Network Adequacy GeoAccess Reports	LA.CONT.01	1 & Attachment TT

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7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care,	Met This requirement is addressed on page 5 and 6 of the Network Adequacy Policy and Procedure.	Network Adequacy GeoAccess Reports	LA.CONT.01	5-6 & Attachment TT
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	Met This requirement is addressed on page 1 of the Network Adequacy Policy and Procedure. Appointment Availability Data Collection report submitted.	Network Adequacy GeoAccess Reports	LA.CONT.01	1
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in Appendix TT with the ratio, distance, and appointment time requirements set in this Section and in Appendices SS and UU.	Met This requirement is addressed on page 1 of the Network Adequacy Policy and Procedure.	Network Adequacy Provider Appointment Accessibility Standards	LA.CONT.01 LA.PRVR.04	1 & Attachment TT 1-2
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.	Met This requirement is addressed on page 3 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	3
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	Met This requirement is addressed on page 1 of the Specialty Healthcare Services Referrals P/P.	Specialty Healthcare Services Referrals	LA.UM.16.01	1
7.8.4	**Hospitals**				
7.8.4.1	Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.				
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. MCO must establish access to the following	Met This requirement is addressed on page 6 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	6

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	within their network of hospital: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.				
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	Met This requirement is addressed on page 6 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	6
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1, or a contract cannot be negotiated, The MCO may contract with out-of-state hospitals to comply with these requirements.	Met This requirement is addressed on page of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	6
7.8.5	**Tertiary Care –** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	Met This requirement is addressed in the Network Adequacy P/P on pages 6 & 7.	Network Adequacy	LA.CONT.01	6, 9
7.8.6	**Direct Access to Women's Health Care –** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	Met This requirement is addressed on page 7 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	7

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7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP;	Met This requirement is addressed on page 1 of the Women's Health Services P/P.	Women's Health Services	LA.UM.01.02	1
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;	Met This requirement is addressed on page 2 and 3 of the Women's Health Services P/P.	Women's Health Services	LA.UM.01.02	2-3
7.8.6.4	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	Met This requirement is addressed on page 1 of the Women's Health Services P/P.	Women's Health Service	LA.UM.01.02	1
7.8.7 7.8.7.1	**Prenatal Care Services -** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	Met This requirement is addressed on page 1 of the Primary Care Provider Auto Assignment P/P. The plan submitted a document entitled Start Smart for Your Baby which is an overview of the Perinatal/Neonatal Management Program.	Primary Care Provider Auto Assignment Start Smart for Your Baby	LA.ELIG.04 LA.SSFB.01	1 4

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7.8.8	**Other Service Providers –** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Met This requirement is addressed on page 7 of the Network Adequacy Policy and Procedure.	Network Adequacy	LA.CONT.01	7
7.8.9	**Non-Emergency Medical Transportation**				
7.8.9.1	The MCO is responsible for **all** necessary Non-Emergency Medical Transportation for its members. This includes transportation to both services covered within the scope of this RFP and all state plan services currently excluded, such as, but not limited to dental and behavioral health.	Met This requirement is addressed in the Access to Transportation P/P.	Access to Transportation Need Logisticare Contract	LA.CONT.03	Covered throughout policy
7.8.9.2	For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall require its transportation contractor to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.	Met This requirement is addressed in the Access to Transportation P/P on page 1.	Access to Transportation	LA.CONT.03	1
7.8.9.3	If a member requests an MCO provider who is located beyond access standards, and the MCO has an appropriate provider within the MCO who accepts new patients, it shall not be considered a violation of the access requirements for the MCO to grant the member's request. However, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this selected provider, and the MCO shall notify the member in writing as to whether or not the MCO will provide transportation to seek care from the requested provider.	Met This requirement is addressed in the Access to Transportation P/P on page 4.	Access to Transportation	LA.CONT.03	4
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services –** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	Met This requirement is addressed in the Network Selection and Retention P/P on page 3. Geo Access reports were provided for both FQHCs and RHCs.	LA.CONT.02	Network Selection & Retention	3
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs) –** SBHC (certified by the DHH Office of Public Health) services are				

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	those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.				
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures	Met This requirement is addressed on page 3 of the Network Selection and Retention P/P.	LA.CONT.02	Network Selection & Retention	3
7.8.13 7.8.13.1	**Local Parish Health Clinics –** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).	Met This requirement is addressed on page 4 of the Network Selection and Retention P/P.	LA.CONT.02	Network Selection & Retention	4
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.	Met This requirement is addressed on page 4 of the Network Selection and Retention P/P.	LA.CONT.02	Network Selection & Retention	4
7.9	**Network Provider Development Management Plan**				
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.206):	Met This requirement is addressed on pages 2 and 3 of the Network Development and Management Plan.	Network Development & Management Plan		Covered throughout document
7.9.1.1	Anticipated maximum number of Medicaid members;	Met This requirement is addressed on page 2 of the Network Development and Management Plan.	Network Development & Management Plan		2
7.891.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Met This requirement is addressed on page 2 of the	Network Development & Management Plan		2

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Network Development and Management Plan.			
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Met This requirement is addressed on page 2 of the Network Development and Management Plan.	Network Development & Management Plan		2
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Met This requirement is addressed on page 2 of the Network Development and Management Plan.	Network Development & Management Plan		2
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Met This requirement is addressed on page 2 of the Network Development and Management Plan.	Network Development & Management Plan		1
7.9.2	The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Met This requirement is addressed on pages 1 through 3 of the Network Development and Management Plan.	Network Development & Management Plan		Covered throughout document
7.9.2.1	Assurance of Adequate Capacity and Services	Met This requirement is addressed in the Network Development and Management Plan. The plan provided geo access reports.	Network Development & Management Plan LA.CONT.01 GeoAccess Reports		Covered throughout documents
7.9.2.2	Access to Primary Care Providers	Met This requirement is addressed in the Network Development and Management Plan and in the Network Adequacy P/P. The plan provided geo access reports which demonstrate the members access to PCPs. [See geo access section].	Network Development & Management Plan LA.CONT.01 GeoAccess Reports		4-5 3
7.9.2.3	Access to Specialists	Met This requirement is addressed in the Network Development and Management Plan and in the Network Adequacy P/P. The plan provided geo access reports which demonstrate the members access to Specialists. [See geo access section].	Network Development & Management Plan LA,CONT.01 GeoAccess Reports		5-6 3-4

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7.9.2.4	Access to Hospitals	Met This requirement is addressed in the Network Development and Management Plan and in the Network Adequacy P/P. The plan provided geo access reports which demonstrate the members access to hospitals. [See geo access section].	Network Development & Management Plan LA.CONT.01 GeoAccess Reports		7 6
7.9.2.5	Timely Access	Met This requirement is addressed on pages 6 and 7 of the Network Development and Management Plan.	Network Development & Management Plan		6-7
7.9.2.6	Service Area	Met This requirement is addressed in the Network Development and Management Plan. The plan provided geo access reports that show the service area covered by the plan's providers, hospitals and specialists.	Network Development & Management Plan GeoAccess Reports		Covered throughout documents
7.9.2.7	Other Access Requirements: Direct Access to Women's Health , Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	Met This requirement is addressed on page 8 of the Network Development and Management Plan.	Network Development & Management Plan		8
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included.	Met This requirement is addressed on pages 8 and 9 of the Network Development and Management Plan under 'Gap Analysis and Intervention'.	Network Development & Management Plan		8-9
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.	Met The contractual language for this requirement is addressed within the Network Development and Management Plan at page 9. The plan provided geo access reports and mapping for all network providers and each provider type demonstrating network capacity.	Network Development & Management Plan GeoAccess Reports		9
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	Met	Network Development and	LA.CONT.05	1

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	contractual and/or program changes and requirements;	The contractual language for this requirement is addressed within the Network Development and Management P/P at page 1.	Management		
7.9.5.2	Monitor network compliance with policies and rules of DHH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	Met The contractual language for this requirement is addressed within the Network Development and Management P/P at page 1.	Network Development and Management	LA.CONT.05	1
7.9.5.3	Evaluate the quality of services delivered by the network;	Met This requirement is addressed within the QAPI Program Description.	QAPI Program Description	LA.QI.01	Covered throughout policy
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Met This requirement is addressed on page 8 of the Network Adequacy Policy and Procedure. Page 9 of the Network Development and Management Plan discusses solutions and arrangements the plan takes in the event of gaps in the service area.	Network Adequacy Network Development & Management Plan	LA.CONT.01	8 9
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	Met Both the Network Adequacy P/P as well as the Evaluation of Provider Availability P/P cover how the plan monitors the adequacy, accessibility and availability of its provider network.	Evaluation of Provider Availability Network Adequacy	LA.QI.04 LA.CONT.01	Covered throughout policies
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Met This requirement is addressed on pages 21 & 44 of the Practitioner Credentialing & Recredentialing P/P.	Practitioner Credentialing & Recredentialing Nondiscriminatory Credentialing/Recredentialing	CC.CRED.01 CC.CRED.04	1
7.9.5.7	Provide training for its providers and maintain records of such training;	Met This requirement is addressed in the Provider Orientation, Provider Visit Schedule and the Provider Visit Record documentation provided.	Provider Orientation Provider Visit Schedule Provider Visit Record	LA.PRVR.13 LA.PRVR.14	Covered throughout documents
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Met This requirement is addressed in the Provider Complaints Policy and Procedure.	Provider Complaints	LA.PRVR.03	2

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7.9.5.9	Ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Met This requirement is addressed in the Provider Complaints Policy and Procedure on pages 2 and 3.	Provider Complaints	LA.PRVR.03	2-3
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Met This requirement is addressed in the Network Development and Management P/P on page 1.	Network Development and Management	LA.CONT.05	1
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	Met This requirement is addressed in the Network Development and Management P/P on page 1.	Network Development and Management	LA.CONT.05.	1
7.10	**Patient-Centered Medical Home (PCMH)**				
7.10.1 7.10.2 7.10.3	Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The MCO shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.	Met This requirement is addressed within the Medical Home Program Description and Implementation Plan. As per the plan – this document is due for a revision within 90 days of the beginning of the new contract (2/2015).	Medical Home – Program Description & Implementation Plan **(Per the RFP, this document is due for revision and submission to DHH 90 days after the new contract begins 2/2015. It will be updated to ensure that all RFP requirements are incorporated into our Implementation Plan)**		Covered throughout document
7.10.4	The MCO shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date that identifies the methodology for promoting practice transformation to providing PCMHs for its members. The Plan shall include, but not be limited to the following:	Met This requirement is addressed within the Medical Home Program Description and Implementation Plan on page 3.	Medical Home – Program Description & Implementation Plan		3
7.10.4.1	Any payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain a medical home practice:	Met This requirement is addressed within the Medical Home Program Description and Implementation	Medical Home – Program Description & Implementation Plan		5

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		Plan on page 5.			
7.10.4.2	Provision of technical support, to assist in their transformation;	Met This requirement is addressed within the Medical Home Program Description and Implementation Plan on pages 4 and 5.	Medical Home – Program Description & Implementation Plan		4, & 5
7.1o.4.3	Facilitation of specialty provider network access and coordination to support the PCMH;	Met This requirement is addressed within the Medical Home Program Description and Implementation Plan on page 5.	Medical Home – Program Description & Implementation Plan		5
7.10.4.4	Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as, the coordination of services with specialty behavioral health providers and other community support services;	Met This requirement is addressed in the PCMH Implementation Plan, page 5.	Medical Home – Program Description & Implementation Plan		New requirement to be developed and submitted within 90 days of go-live.
7.10.4.5	Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Met This requirement is addressed within the Medical Home Program Description and Implementation Plan on page 4.	Medical Home – Program Description & Implementation Plan		4
7.10.4.6	Methodology for evaluating the level of practice participation, level of practice transformation and any capacity and/or health outcomes achieved, The findings from all evaluations shall be included in the annual update of the PCMH Implementation Plan.	Met This requirement is addressed in the PCMH Implementation Plan, pages 4 & 5.	Medical Home – Program Description & Implementation Plan		New requirement to be developed and submitted within 90 days of go-live.
7.12	**Coordination with Other Service Providers**				
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Met This requirement is addressed in the Provider Orientation materials at page 2 and the Provider Manual at page 50.	Provider Orientation /10 Provider Services/Provider_Manual.docx	LA.PRVR.13 Provider Responsibilities	2 50
7.13	**Subcontract Requirements**				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.1	In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.	Met This requirement is addressed on page 8, subsection 18, of the Network Selection and Retention Policy and Procedure.	Network Selection and Retention	LA.CONT.02	2
7.13.2	The MCO shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.	Met This requirement is addressed in the Network Selection and Retention P/P as well as in the Cred/Recred P/P.	Network Selection and Retention Practitioner Credentialing/Recredentialing	LA.CONT.02 CC.CRED.01	Covered throughout policies
7.13.2.1	Within 30 days of the MCO signing the contract, it shall provide DHH with written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws	Met This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy and in the contract submission documentation.	Practitioner Credentialing/Recredentialing	CC.CRED.01	Covered throughout policy
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Met This requirement is addressed on page 2 of the Network Selection and Retention Policy and Procedure.	Network Selection and Retention	LA.CONT.02	2
7.13.3	As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the MCO shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:	Met This requirement is addressed within the Oversight of Delegated Services Policy and Monitoring Plan.	Delegated Vendor Oversight Attachment		Covered throughout document
7.13.3.1	All provider subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;	Met This requirement is addressed within the Oversight of Delegated Services Policy and Monitoring Plan. The Vendor Oversight Program documentation also addresses this requirement.	Delegated Vendor Oversight Attachment Vendor Oversight Program	CC.COMP.21	Covered throughout documents
7.13.3.2	DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Met This requirement is addressed on page 6 of the Network Selection and Retention Policy and Procedure.	Network Selection & Retention	LA.CONT.02	6

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.3.3	The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated;	Met This requirement is addressed within the Oversight of Delegated Services Policy and Monitoring Plan. The Vendor Oversight Program documentation also addresses this requirement. Annual corporate quality audits are performed by Centene. The Annual Vendor Audit P/P was submitted by the plan.	Vendor Oversight Program Delegated Vendor Oversight Attachment Annual Corporate Quality Audits	CC.COMP.21	5 Covered throughout documents
7.13.3.4	The MCO must have a written agreement between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;	Met This requirement is addressed within the Oversight of Delegated Services Policy and Monitoring Plan. The Vendor Oversight Program documentation also addresses this requirement. The plan provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate in the Vendor Oversight Program, Invoking Vendor Penalties, and QIP CAP documentation.	Delegated Vendor Oversight Attachment Vendor Oversight Program Invoking Vendor Penalties QIP CAP	CC.COMP.21 CC.COMP.21_01 CC.COMP.21_02	Covered throughout documents
7.13.3.5	The MCO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;	Met This requirement is addressed in the Delegated Vendor Oversight Plan and the Vendor Oversight Program P/P.	Delegated Vendor Oversight Attachment Vendor Oversight Program	CC.COMP.21	Covered throughout documents
7.13.3.6	The MCO shall identify deficiencies or areas for improvement, and take corrective action; and	Met The plan identifies deficiencies or areas for improvement and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate in the Vendor Oversight Program, Invoking Vendor Penalties, and QIP CAP documentation.	Delegated Vendor Oversight Attachment Vendor Oversight Program Invoking Vendor Penalties QIP CAP	CC.COMP.21 CC.COMP.21_01 CC.COMP.21_02	Covered throughout documents
7.13.3.7	The MCO shall specifically deny payments to subcontractors for Provider Preventable Conditions.	Met This requirement is addressed in the Product	Product Attachment A		10

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Attachment documentation that is part and parcel of the LA Coordinated Care Network Service Agreement.			
7.13.4	The MCO shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Met This requirement is addressed in the Delegated Vendor Oversight Attachment and the Vendor Oversight Program documentation.	Delegated Vendor Oversight Attachment Vendor Oversight Program	CC.COMP.21	Covered throughout documents. Also, have already done for existing.
7.13.5	Notification of amendments or changes to any provider subcontract which, in accordance with Section 7.6 of this RFP, materially affects this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with Section 23.1 of this RFP.	Met Contract Process document is legible and addresses this requirement.	Contract Process_DHH_vs		1
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5)or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	Met This requirement is addressed in the Practitioner Credentialing and Recredentialing documentation provided.	Practitioner Credentialing/Recredentialing	CC.CRED.01	1, 6, 14, 25, 31, 43
7.13.7	The MCO shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the MCO's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the MCO shall provide immediate written notice to the provider.	Met This requirement is addressed on page 2 of the Provider Termination P/P.	Provider Termination	LA.CONT.23	2
7.13.8	If termination is related to network access, the MCO shall include in the notification to DHH their plans to notify MCO members of such change and strategy to ensure timely access to MCO members through out-of-network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.	Met This requirement is addressed on page 2 of the Provider Termination P/P. Pages 1 through 7 of the Member Advisory of Provider Termination is the document that shows the communication to the members of a provider termination.	Provider Termination Member Advisory of Provider Termination	LA.CONT.23 LA.MBRS.27	2 1-7

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.13.9	The MCO shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	Met This requirement is addressed on page 1 of the Member Advisory of Provider Termination P/P.	Member Advisory of Provider Termination	LA.MBRS.27	1
7.13.10	All subcontracts executed by the MCO pursuant to this Section shall, at a minimum, include the terms and conditions listed in Section25 of this RFP. No other terms or conditions agreed to by the MCO and its subcontractor shall negate or supersede the requirements in Section 25.	Met This requirement is addressed on page 1 of the Network Adequacy P/P and is written in the p	Network Adequacy Provider Contract Attachment A	LA.CONT.01	1 1
7.14	**Provider-Member Communication Anti-Gag Clause**				
7.14.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	Met This requirement is addressed in the Provider Manual.	Below sections roll up into this item.		
7.14.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Met This requirement is addressed in the Provider Manual on page 50.	/10 Provider Services/Provider_Manual.docx	Rights and Responsibilities	50
7.14.1.2	Any information the member needs in order to decide among relevant treatment options;	Met This requirement is addressed in the Provider Manual on page 50.	/10 Provider Services/Provider_Manual.docx	Rights and Responsibilities	50
7.14.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Met This requirement is addressed on page 8 of the Product Attachment.	Product Attachment A		8
7.14.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Met This requirement is addressed on page 8 of the Product Attachment.	Product Attachment A		8
7.14.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.14.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Met This requirement is addressed on page 6 of the Provider Contract and page 9 of the Product Attachment.	Provider Contract Product Attachment		6 9
7.15	**Pharmacy Network, Access Standards and Reimbursement**				
7.15.1	**Pharmacy Network Requirements**				
7.15.1.1	The MCO shall provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.	Met This requirement is addressed in the plan's Initial Credentialing Process P/P.	Initial Credentialing Process Ongoing Monitoring of Sanctions & Compliance	USS.CRED.01 USS.CRED.03	Covered throughout documents
7.15.1.2	No MCO may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.	Met This requirement is addressed in the plan's Initial Credentialing Process P/P.	Initial Credentialing Process	USS.CRED.01	Covered throughout document
7.15.1.3	The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies: • Names, locations and telephone numbers. • Any non-English languages spoken. • Identification of hours of operation, including identification of providers that are open 24-hours per day. • Identification of pharmacies that provide vaccine services. • Identification of pharmacies that provide delivery services.	Met This requirement is addressed in the Provider Directory Portico on page 1.	Provider Directory Portico P/P for Provider Directory Provider Directory http://apps.louisianahealthconnect.com/findadoc/	CC.PRVR.19	Covered throughout document
7.15.1.4	The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.	Met This requirement is addressed in the Provider Directory Portico on page 2.	Provider Directory Portico	CC.PRVR.19	2

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.15.1.5	The MCO shall ensure PBM/PBA has a network audit program that includes, at a minimum: • Random audits to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. The MCO shall not utilize contingency-fee based pharmacy audits. • The MCO shall submit to DHH the policies of its audit program for approval.	Met This requirement is addressed in the Pharmacy Audit P/P.	Pharmacy Audits	USS.PND.11	Covered throughout policy
7.15.1.6	The MCO shall ensure that pharmacies submit the NPI of the prescriber on claims.	Met This requirement is addressed on pages 6 and 30 of the US Script Participating Pharmacy Agreement.	US Script Inc Participating Pharmacy Agreement	USS.PPAV2013	6
7.15.1.7	The MCO must educate network providers about how to access their formulary and PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.	Met This requirement is addressed on page 30 of the Provider Manual.	/10 Provider Services/Provider_Manual.docx US Script Pharmacy /10 Provider Services/Provider_Manual.docx	Pharmacy Program	30 16, 19
7.15.1.10	Thirty days after enrollment of a new MCO into Bayou Health, DHH will require that the MCO and PBM receive active agreement from pharmacy providers to participate in the MCO's pharmacy network, even if the pharmacy provider has an existing relationship with the MCO's PBM. This means that if a pharmacy provider is already contracted with an MCO's PBM for other coverage products, notification alone will not be sufficient for that pharmacy provider to be considered part of the PBM's Medicaid network. The pharmacy provider must actively agree to the terms of the Medicaid contract addendum.	Met This requirement is addressed in LA-LHCC Addendum (Contract).	US Script Inc. Amendment to PPA for LHCC	LA-LHCC Retail Addendum 070113	Covered throughout document
7.15.3	**Specialty Drugs and Specialty Pharmacies**				
7.15.3.1	The MCO may limit distribution of specialty drugs from a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and is willing to accept the terms of the MCO's agreement.	Met This requirement is addressed on page 2 of the Specialty Pharmacy Program Policy and Procedure.	Specialty Pharmacy Program	LA.PHAR.12	2
7.15.3.2	A specialty drug is defined as one that is:	Met This requirement is addressed on page 1 of the Specialty Pharmacy Program Policy and Procedure.	Specialty Pharmacy Program	LA.PHAR.12	1

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
7.15.3.2.1	Not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or	Met This requirement is addressed on page 1 of the Specialty Pharmacy Program Policy and Procedure in section A.	Specialty Pharmacy Program	LA.PHAR.12	1
7.15.3.2.2	Includes at least two of the following characteristics: • requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or • must be administered, infused or injected by a health care professional; or • the drug is indicated primarily for the treatment of: a complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or a rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or • the total monthly cost is $3,000 or more.	Met This requirement is addressed on page 1 of the Specialty Pharmacy Program Policy and Procedure in section B.	Specialty Pharmacy Program	LA.PHAR.12	1