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| 6.28 | **Referral System for Specialty Healthcare** | | | | |
| 6.28.1 | The MCO shall have a referral system for MCO members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The MCO shall provide the coordination necessary for referral of MCO members to specialty providers. The MCO shall assist the member in determining the need for services outside the MCO network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record. | Met:<br>Non Clinical Intake and Initial Screening Policy pg 3 (Referral System for Specialty HealthCare) | Management of Care Transitions Policy<br><br>06.13 Non-Clinical Intake and Initial Screening – See under 8.4 | Section IV – Policy<br>Section V – Policy Provisions<br><br>Addenda | Page 1<br>Pages 2 -3<br><br>Pg. 3 |
| 6.28.2 | The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements: | Met:<br>Regulatory Compliance Addendum Pg 3 (Referral System for Specialty HealthCare) | 03.12 Regulatory Compliance<br>See under 8.1 | Addenda | Pg. 3 |
| 6.28.2.1 | When a referral from the member's PCP is and is not required (See Section §8.5.1.6 Exceptions to Service Authorization and/or Referral Requirements); | Met:<br>Non Clinical Intake and Initial Screening Policy pg 3 (Referral System for Specialty HealthCare) | 06.13 Non-Clinical Intake and Initial Screening<br>See under 8.4 | Addenda | Pg. 3 |
| 6.28.2.2 | Process for member referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the member; | Met:<br>Out of Network Requests and Continuing Care Policy Pg 2-, pg 6-Referral System for Specialty HealthCare | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Policy - Provisions C1<br>Addenda | Pg. 2<br>Pg. 6 |
| 6.28.2.3 | Process for providing a standing referral when a member with a condition requires on-going care from a specialist; | Met:<br>Non Clinical Intake and Initial Screening Policy Pg 3 | 06.13 Non-Clinical Intake and Initial Screening<br>See under 8.4 | Addenda | Pg. 3 |
| 6.28.2.4 | Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time; | Met:<br>Non Clinical Intake and Initial Screening Policy Pg 3 | 06.13 Non-Clinical Intake and Initial Screening<br>See under 8.4 | Addenda | Pg. 3 |
| 6.28.2.5 | Process for member referral for case management; | Met:<br>Patient Centered Medical | 02.14 Interdepartmental and External Entity Coordination | Policy - Provisions A1-2<br>Addenda | Pg. 1<br>Pg. 4 |

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| | | Home Program Description refers to a High Risk Medical/Behavioral Case Management program. The program description included a discussion of referral sources and referral process. | See under 6.28 | | |
| 6.28.2.6 | Process for member referral for chronic care management; | Met:<br>Patient Centered Medical Home Program Description refers to a Chronic Care Management Program. The identification process for this program is described. | *02.14 Interdepartmental and External Entity Coordination*<br>*See under 6.28* | Policy - Provisions A1-2<br>Addenda | Pg. 1<br>Pg. 4 |
| 6.28.2.7 | Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship. | Met:<br>Program Description , Page 35 | QM program description<br>Medical record review audit too<br>Medical record P and P<br><br>Provider Manual (See 10.4) | 12/24-QM program page 34<br>12/24- Provider Manual page 28 | 17,23 and 24<br>Entire document<br>Page 39-43 |
| 6.28.2.8 | Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record. | Met:<br>Provider Manual Pg 37 | QM program description<br>Medical record review audit too<br>Medical record P and P<br>Provider Manual (See 10.4) | | 17,23 and 24<br>Entire document<br>Page 39-43 |
| 6.28.2.9 | There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and | Met:<br>Provider Manual Pg 37 | QM program description<br><br>Medical record review audit too<br>Medical record P and P<br><br>Provider Manual (See 10.4) | | 17,23 and 24<br><br>Entire document<br>Page 39-43 |
| 6.28.2.10 | Process for referral of members for Medicaid State Plan services that are excluded from MCO core benefits and services and that will continue to be provided through fee-for-service Medicaid. | Met: Interdepartmental and External Entity Coordination Policy pg 4 Addendum | 02.14 Interdepartmental and External Entity Coordination<br>See under 6.28 | Policy - Provisions A1-2<br>Addenda | Pg. 1<br>Pg. 4 |
| 6.28.2.11 | The MCO shall develop electronic, web-based referral processes and systems. | Met:<br>Quick Reference Guide | Referral Submission<br>QUICK REFERENCE | All Sections | Entire Document |

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| **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. The MCO shall ensure member-appropriate PCP choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, 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 to identify and overcome barriers to primary and preventive care that a MCO member may encounter. | Met:<br>Out of Network Requests and Continuing Care Pg 6, 6.29-Care Coordination, Continuity of Care, Care Transition | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | IV Policy<br><br>Policy - Statement<br>Addenda | Page 1<br><br>Pg. 1<br>Pg. 6 |
| 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. | Met:<br>Out of Network Requests and Continuing Care Pg 6, 6.29-Care Coordination, Continuity of Care, Care Transition | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | All sections<br><br>Addenda | Pages 1-6<br><br>Pg. 6 |
| 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: | Met:<br>Out of Network Requests and Continuing Care Pg 7, 6.29-Care Coordination, Continuity of Care, Care Transition | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | All sections<br><br>Addenda | Pages 1-6<br><br>Pg. 7 |
| 6.29.2.1 | Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs; | Met:<br>LA Addendum-Utilization Mgt Program Description-Pg 4 | Management of Care Transitions Policy (located in 6.28)<br><br>Louisiana Addendum: Utilization Management Program Description<br>See under 8.2 | IV Policy<br><br>Prospective/Pre-service Review | Page 1<br><br>Page 4 |
| 6.29.2.2 | Coordinate care between PCPs and specialists; | Met:<br>LA Addendum-Utilization Mgt Program Description-Pg 4 | Management of Care Transitions Policy (located in 6.28)<br><br>Louisiana Addendum: Utilization | V Policy Provisions<br><br>Prospective/Pre-service | Pages 2-3<br><br>Pg. 4 |

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| | | | Management Program Description<br>See under 8.2 | Review | |
| 6.29.2.3 | Coordinate care for out-of-network services, including specialty care services; | Met:<br>Out of Network Requests and Continuing Care Pg 7, 6.29-Care Coordination, Continuity of Care, Care Transition | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | V Policy Provisions<br><br>Addenda | Pages 2-3<br><br>Pg. 7 |
| 6.29.2.4 | Coordinate MCO provided services with services the member may receive from other health care providers; | Met:<br>Person Centered Care Model Program Description-community resource coordination | Person Centered Care Model Program Description | Introduction and Scope<br>High Risk Medical/Behavioral Case Management<br>Member Enrollment and Program Information | Page 3<br>Page 8<br><br>Pages 14-15 |
| 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; | Met:<br>HAP and POC monitoring and evaluation includes discussion of reporting to all entities involved in care | Person Centered Care Model Program Description<br><br>PCCM Transitional Case Management Program Procedure | Health Action Plan (HAP) and Person Centered Plan of Care (POC)<br>Monitoring and Evaluation<br><br>Scope | Pages 15-16<br><br>Page 16<br><br>Page 1 |
| 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 subparts A and E, and other applicable state or federal laws; | Met:<br>Management of Care Transitions Policy (Role of the PCP) , pg 5 | Management of Care Transitions Policy<br>See 6.28<br><br>03.10 Information Security<br>See under 6.28 | V Policy Provisions, Section D – Role of the PCP in Managing Care Transitions<br><br>Policy - Provisions B1<br>Addenda | Page 5<br><br>Pg. 1<br>Pg. 15 |
| 6.29.2.7 | Maintain and operate a formalized hospital and/or institutional discharge planning program; | Met:<br>Transitional Care Mgt process (PCMM pg 10) discusses pre and post hospital discharge program | Person Centered Care Model Program Description<br><br>PCCM Transitional Case Management Program Procedure | Transitional Case Management<br><br>Scope<br>Section 3 – TCM Interventions | Pages 9-10<br><br>Page 1<br>Pages 3-4 |
| 6.29.2.8 | Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge; | Met:<br>PCCM Case Mgt Program Procedure Section 3-medication reconciliation | Person Centered Care Model Program Description | Transitional Case Management<br>Health Assessment | Pages 9-10<br><br>Page 15 |

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| | | discussion | PCCM Transitional Case Management Program Procedure | Scope<br>Section 3 – TCM Interventions | Page 1<br>Pages 3-4 |
| 6.29.2.9 | Document authorized referrals in its utilization management system; and | Met:<br>Non clinical Intake and Initial Screening discusses referral entry- pg 1 | 06.13 Non-Clinical Intake and Initial Screening<br>See under 8.4 | Addenda | Pg. 10 |
| 6.29..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; | Met:<br>Out of Network Requests and Continuing Care Pg 7, 6.29-Care Coordination, Continuity of Care, Care Transition | 06.21 Out of Network Requests and Continuing Care | Addenda | Pg. 7 |
| **6.30** | **Continuity of Care for Pregnant Women** | | | | |
| 6.30.1 | In the event a Medicaid eligible entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider. | Met:<br>Out of Network Requests and Continuing Care –Pg 7 (Continuity of Care for Pregnant Women) | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 7 |
| 6.30.2 | In the event a Medicaid eligible entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health. | Met:<br>Out of Network Requests and Continuing Care –Pg 8 (Continuity of Care for Pregnant Women) | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 8 |
| 6.30.3 | In the event a member entering the MCO is in her second or third trimester | Met: | 06.21 Out of Network Requests and | Addenda | Pg. 8 |

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| | of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) days postpartum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period. | Out of Network Requests and Continuing Care –Pg 8 (Continuity of Care for Pregnant Women) | Continuing Care<br>See under 8.5 | | |
| 6.30.4 | The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services. | Met:<br>Provider Manual-Billing and Encounter Submission Pg 69 | Provider Manual-(Section10.4) | Medicaid Enrollees Billing and Encounter Submission | Pg. 69 |
| **6.31** | **Preconception/Inter-conception Care** | | | | |
| 6.31.0 | For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as prior authorization shall not be required for approval. | Met:<br>Utilization Mgt Program Description-Pg 5-Obstetrics/Maternity care/Family planning | Louisiana Addendum: Utilization Management Program Description<br>See under 8.2 | Obstetrics/Maternity Care/Family Planning | Pg. 5 |
| **6.32** | **Continuity of Care for Individuals with Special Health Care Needs** | | | | |
| 6.32.0 | In the event a Medicaid/CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider. | Met:<br>Out of Network Requests and Continuing Care-Pg 8 | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 8 |
| **6.3** | **Pharmacy Services** | | | | |
| 6.3.2 | **Formulary-**<br>The MCO is required to have a Formulary that follows the minimum requirements below: | | | | |
| 6.3.2.1 | The Formulary shall be kept up-to-date and available to all providers and members via MCO web site and electronic prescribing tools. | Met:<br>LA Rx 001 Procedure 2 | LA Rx 001 | Procedure, 2 | Page 2 |

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| 6.3.2.3 | The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request. | Met:<br>Policy 001 indicates formulary will be updated regularly and upon DHH request | Rx 001 Pharmaceutical Management Systems P&T Committee | Procedure, Responsibilities, a, x<br><br>Number 2-PDL | Page 12<br><br>Pg.2 |
| 6.3.2.8 | The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs. | Met:<br>Non Preferred drugs policy | Non-preferred Drugs Policy | Entire document | Entire document |
| 6.3.3 | **Preferred Drug List** | | | | |
| 6.3.3.6 | The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs. | Met:<br>Non Preferred Drugs Policy | Non-preferred Drugs Policy | Entire document | Entire document |
| **6.33** | **Continuity of Care for Pharmacy Services** | | | | |
| 6.33.1 | The MCO must submit for approval, a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services or enrollment in the MCO's plan. The MCO shall continue any treatment of antidepressants and antipsychotics for at least 60 days after enrollment into the MCO's plan. Additionally, an enrollee that is, at the time of enrollment, in the MCO receiving a prescription drug that is not on the MCO's Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days. | Met:<br>LA Pharmacy Benefit-LA Rx 001 Procedure 2 | Rx 011 Pharmacy Transitional Supply<br><br>LA Rx 001 | Policy and Procedure A<br><br>Procedure 2, c | Page 1 and 2<br><br>Page 2 |
| **6.34** | **Continuity for Behavioral Health Care** | | | | |
| 6.34.1 | 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. | Met:<br>Behavioral Health Policy Services addendum pg 2 | Behavioral Health Services Policy Addendum<br><br>SOP UHC Magellan Collaboration<br><br>Provider Manual (See 10.4) | Overview, Sections 7.2.1.2, 7.2.2<br><br>Care Coordination Plan for Services<br><br>Role of Non BH Care Provider | Pages 1-2<br><br>Page 2<br><br>Page 49, column 1 |
| 6.34.2 | The MCO shall establish a formal memorandum of understanding with the SMO, effective the begin date of the contract, to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. | Met:<br>SOP UHC Magellan Collaboration-pg 1-5 | Community & State Intensive Medical Behavioral Case Management Program<br><br>SOP UHC Magellan Collaboration | Sections 4.3.2 – 4.3.5<br><br>Overview, Care Coordination Plan for Services | Pages 5-7<br><br>Pages 1-5 |

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| 6.34.3. | In order to ensure continuity and coordination of care for members who have been determined by a medical provider to need specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the MCO shall be responsible for referring to the SMO. | Met: Util Mgt Program Description-Substance Abuse/Behavioral Health pg 7 | Integration of Physical and BH Case Management<br><br>Community & State Intensive Medical Behavioral Case Management Program<br><br>SOP UHC Magellan Collaboration<br><br>Louisiana Addendum: Utilization Management Program Description See under 8.2<br><br>Provider Manual (See 10.4) | V Policy Provisions, Section B<br><br>Section 4.1.3 – 4.1.4<br><br>Care Coordination Plan for Services<br><br>VII Substance Abuse/Behavioral Health<br><br>Role of UHC Community Plan CM in BH Services | Pages 1-2<br><br>Page 4Pages 2, 4-5<br><br>Pg. 7<br><br>Page 48, Column 2 |
| 6.34.4 | 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. Payment for the emergency service is the responsibility of the MCO, payment for any follow-up care is the responsibility of the SMO. | Met: SOP UHC Magellan Collaboration –Care Coordination Plan for Services-Pg 3 | SOP UHC Magellan Collaboration<br><br>Provider Manual (See 10.4) | Care Coordination Plan for Services<br><br>Role of UHC Community Plan CM in BH Services | Page 3<br><br>Page 48, Column 2 |
| 6.34.5 | The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113. | Met: SOP UHC Magellan Collaboration –Care Coordination Plan for Services-Pg 3 | Louisiana SOP LA SOP 005 | Care Coordination Plan for Services between United Healthcare Community Plan and Magellan Behavioral Health Services | Page 3 |
| 6.34.6 | The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider. | Met: Integration of Physical and BH Case Mgt Section V , B Integration | Integration of Physical and BH Case Management<br><br>Community & State Intensive Medical Behavioral Case Management Program | V Policy Provisions, Section B<br><br>Section 4.3.3 | Pages 1-2<br><br>Page 6 |
| 6.34.7 | The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care. | Met: SOP-UHC Magellan Collaboration pg 2 | Integration of Physical and BH Case Management<br><br>Community & State Intensive Medical | V Policy Provisions, Section B<br><br>Section 4.3.4 -4.3.5 | Pages 1-2<br><br>Pages 6-7 |

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| | | | Behavioral Case Management Program<br><br>SOP UHC Magellan Collaboration<br><br>Person Centered Care Model Program Description (located in 6.29) | <br><br>Care Coordination Plan for Services<br><br>Integration of Medical and Behavioral Health | <br><br>Pages 2 -4<br><br>Page 9 |
| 6.34.8 | 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 provides, facilities and agencies and require complex coordination of benefits and services. | Met:<br>PCCare Model Program Description –Integration of Medical and Behavioral Health pg 9 | Community & State Intensive Medical Behavioral Case Management Program<br><br>SOP UHC Magellan Collaboration<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.1.3 – 4.1.4<br><br>Section 4.3.4 -4.3.5<br><br>Care Coordination Plan for Services<br>Integration of Medical and Behavioral Health | Page 4<br><br>Pages 6-7<br><br>Pages 3 -4<br><br>Page 9 |
| 6.34.9 | The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures. | Met:<br>BH Medical Director Job Description-Item 4 and 6-Training , providing education | BH Medical Director Job description<br><br>Community & State Intensive Medical Behavioral Case Management Program<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>Louisiana Addendum: | Items 4 and 6<br><br>Section 4.1.3 – 4.1.4<br><br>Training<br><br>VII. Substance Abuse/Behavioral Health | Page 1<br><br>Page 4<br><br>Pages 7-8<br><br>Pg. 7 |
| **6.35** | **Continuity for DME, Prosthetics, Orthotics, and Certain Supplies** | | | | |
| 6.35.0 | In the event a Medicaid member entering the MCO is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before MCO enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred (within timeframe specified in this RFP) without disruption, whichever is less. The MCO must also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the | Met:<br>Out of Network Requests and Continuing Care-(Continuity for DME, Prosthetics, etc) pg 9 | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 9 |

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| | member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the MCO. | | | | |
| **6.36** | **Care Transition** | | | | |
| 6.36.1 | The MCO shall provide active assistance to members when transitioning to another MCO or to Medicaid FFS. | Met:<br>Out of Network Requests and Continuing Care-pg 10 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | All Sections<br><br>Addenda | All pages<br><br>Pg. 10 |
| 6.36.2 | The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO unless the member has been identified as an ISHCN (see section 6.32 for exception of ISHCN.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members. | Met:<br>Out of Network Requests and Continuing Care-pg 10 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | All Sections<br><br>Addenda | All pages<br><br>Pg. 10 |
| 6.36.3 | If a member is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care. | Met:<br>Out of Network Requests and Continuing Care-pg 10 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | IV Policy<br><br>Addenda | Page 1<br><br>Pg. 10 |
| 6.36.4 | Upon notification of the member's transfer, the receiving MCO shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving MCO shall be the responsibility of the relinquishing MCO. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing MCO's | Met:<br>Out of Network Requests and Continuing Care-pg 10 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | V Policy Provisions, Section A<br><br>Addenda | Pages 2-3<br><br>Pg. 10 |

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| | PCP within ten (10) business days of the receiving MCO's PCP's request. | | | | |
| 6.36.4.1 | 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. | Met:<br>Out of Network Requests and Continuing Care-pg 11 | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 11 |
| 6.36.4.2 | During transition, the MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider. | Met:<br>Out of Network Requests and Continuing Care-pg 11 | 06.21 Out-of-network requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 11 |
| 6.36.5 | Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor. | Met:<br>Out of Network Requests and Continuing Care-pg 11 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | V policy Provisions, Section A<br><br>Addenda | Pages 2-3<br><br>Pg. 11 |
| 6.36.7 | Special consideration should be given to, but not limited to, the following: | | | | |
| 6.36.7.1 | Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition; | Met:<br>Out of Network Requests and Continuing Care-pg 12 | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 12 |
| 6.36.7.2 | Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services; | Met:<br>Out of Network Requests and Continuing Care-pg 12 | 06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Addenda | Pg. 12 |
| 6.36.7.3 | Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth; | Met:<br>Out of Network Requests and Continuing Care-pg 12 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | IV Policy<br><br>Addenda | 3<br><br>Pg. 12 |
| 6.36.7.4 | Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization; | Met:<br>Out of Network Requests and Continuing Care-pg 12 | Management of Care Transitions Policy (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | IV Policy<br><br>Addenda | 3<br><br>Pg. 12 |
| 6.36.8 | When relinquishing members, the MCO is responsible for timely | Met: | Management of Care Transitions Policy | IV Policy, V Policy | Pages 1-3 |

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| | notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members. The MCO, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with MCO and service information, emergency numbers and instructions on how to obtain services. | Out of Network Requests and Continuing Care-pg 12 | (located in 6.28)<br><br>06.21 Out of Network Requests and Continuing Care<br>See under 8.5 | Provisions, Section A<br><br>Addenda | <br><br>Pg. 12 |
| **6.37** | **Case Management (CM)** | | | | |
| 6.37.1 | The MCO shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, social services, and basic 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 and cost-effective service 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. | Met<br><br>Addressed in documents resubmitted by UHC post onsite visit. | Community & State High Risk Medical Behavioral Case Management Program (located in 6.34)<br><br>Integration of Physical and BH Case Management (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>PCCM Louisiana Addendum (located in Core Benefits and Services 6.0) | All Sections<br><br>V Policy Provisions, Section B<br><br>Introduction and Scope Objectives<br><br>Program Documentation | Pages 1-11<br><br>Pages 1-2<br><br>Pages 1-2<br>Page 2<br><br>Page 2 |
| 6.37.2 | Case Management program functions shall include but not be limited to: | | | | |
| 6.37.2.1 | Early identification of members who have or may have special needs; | Met:<br>Community and State Intensive Medical Behavioral Case Mgt Program (pg 1) and PCCM Program Description pg 13 | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 1<br><br>Member Identification and Stratification | Page 1<br><br>Page 13 |
| 6.37.2.2 | Assessment of a member's risk factors; | Met:<br>Community & State Intensive Medical Behavioral Case Management Program (pg 4) and Person Centered Care Model Program Description (pg 15) | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.1, Numbers 4.1.1 – 4.1.5<br><br>Health Assessments | Page 4<br><br>Page 15 |
| 6.37.2.3 | Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate; | Met:<br>PCCM Program | Person Centered Care Model Program Description (located in 6.29) | Introduction and Scope<br>Training | Page 3<br>Page 7 |

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| | | Description Pg 7 Training | | Member Enrollment and Program Information | Page 14 |
| 6.37.2.4 | Development of an individualized treatment plan, in accordance with Section 6.18.4; | Met:<br>Community and State Intensive Medical Behavioral Case Mgt Program description (Care plan development/Maintenance) pg 4-5 | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.2, Numbers 4.2.1 – 4.2.10<br><br>Health Action Plan (HAP) and Person Centered Health Action Plan (HAP) and Person Centered Plan of Care (POC) (POC)<br>Monitoring and Evaluation | Pages 4 – 5<br><br>Pages 15-16<br><br>Page 16 |
| 6.37.2.5 | Referrals and assistance to ensure timely access to providers; | Met:<br>Community and State Intensive Medical Behavioral Case Mgt Program description (Referrals) pg 6 | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34) | Section 4.3, Number 4.3.4 | Page 6 |
| 6.37.2.6 | Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed; | Met:<br>Community and State Intensive Medical Behavioral Case Mgt Program Description (pg 7)-Coordination of Care | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.3, Number 4.3.5<br><br>Introduction and Scope<br>Training<br>High Risk Medical/Behavioral Case Management<br>Community Engagement<br>Connecting to Vendor Partners | Pages 6 – 7<br><br>Pages 3-4<br>Page 7<br>Page 8<br><br>Page 10<br>Page 12 |
| 6.37.2.7 | Monitoring; | Met:<br>Person Centered Care Model Program Description (pg 16-17) Monitoring and Evaluation | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.3, Numbers 4.3.1 – 4.3.3<br><br>Monitoring and Evaluation | Pages 5 – 6<br><br>Page 16 |
| 6.37.2.8 | Continuity of care; and | Met:<br>Management of Care Transitions (entire | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34) | Section 4.3, Number 4.3.8 | Page 7 |

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| | | document) | Person Centered Care Model Program Description (located in 6.29) | Transitional Case Management | Page 9 |
| 6.37.2.9 | Follow-up and documentation. | Met:<br>Community & State Intensive Medical Behavioral Case Management Program (Community and State Documenting Activities, Tools and Technology) Pgs 5-6, 9 | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.3, Numbers 4.3.1 – 4.3.3<br>Section 6, Numbers 6.1 – 6.6<br><br>Health Action Plan (HAP) and Person Centered Health Action Plan (HAP) and Person Centered Plan of Care (POC) (POC) | Pages 5 - 6, 9<br><br>Pages 15-16 |
| **6.38** | **Case Management (CM) Policies and Procedures** | | | | |
| 6.38.0 | 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: | Met<br>Addressed in documents resubmitted by UHC post onsite visit | *Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)*<br><br>*Community & State Community Engagement Program Procedure*<br><br>*PCCM Louisiana Addendum (located in 6.0)* | *All Sections*<br><br>*All Sections*<br><br>*Program Documentation* | *All pages*<br><br>*All pages*<br><br>*Page 2* |
| 6.38.1 | A process to offer voluntary participation in the Case Management Program to eligible members; | Met:<br>2015 Person Centered Care Model Program Description, pg 14, Member Enrollment and Program Information | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 2, Numbers 2.1 - 2.2<br>Section 3, Numbers 3.1 – 3.4<br>Section 3, Number 3.5-3.6<br><br>Member Enrollment and Program Information | Pages 1-3<br><br>Page 3<br><br>Page 14 |
| 6.38.2 | Identification criteria, process, and triggers for referral and admission into the Case Management Program; | Met:<br>2015 Person Centered Care Model Program Description, pg 13, Identification | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34) | Section 1, Numbers 1.1 – 1.3<br>Section 2, Numbers 2.1 – 2.2<br>Section 3, Numbers 3.1 - | Pages 1-3 |

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| | | | Community & State Community Engagement Program Procedure | Section 1 | Page 1 |
| | | | Person Centered Care Model Program Description (located in 6.29) | Member Identification and Stratification | Pages 12-13 |
| 6.38.3 | Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited<br>to, the following:<br>• Reproductive aged women with a history of prior poor birth outcomes; and<br>• High risk pregnant women | Met<br><br>Addressed in documents resubmitted by UHC post onsite visit, | Community & State Engagement Program Procedure<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description. V3 (located in 6.0) | Section 1, Number 1.3<br>Section 3<br><br>Healthy First Steps<br>Member Identification and Stratification | Page 1<br>Page 3<br><br>Pages 10-11<br>Page 13<br><br>Page 15 |
| 6.38.4 | The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers; | Met:<br>2015 Person Centered Care Model Program Description, pgs 15-16, Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Community & State Community Engagement Program Procedure<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.2, Numbers 4.2.1 – 4.2.10<br><br>Section 5<br><br>Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Pages 4-5<br><br>Pages 4 -6<br><br>Pages 15-16 |
| 6.38.5 | A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning; | Met:<br>2015 Person Centered Care Model Program Description, pg 15, Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 4.2, Numbers 4.2.4, 4.2.10<br><br>Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Pages 4-5<br><br>Pages 15-16 |
| 6.38.6 | Procedures and criteria for making referrals to specialists and subspecialists; | Met:<br>Community & State Intensive Medical Behavioral Case Management Program, | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Informing and Educating Providers Policy | Section 4.3.3, 4.3.5<br><br>V Policy Provisions, | Pages 6-7<br><br>Page 1 |

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| | | pgs 6-7, Section 4.3.4, 4.3.5 | Person Centered Care Model Program Description | Section B<br>Member Enrollment and Program Information | Page 14 |
| 6.38.7 | Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and | Met<br><br>1 Procedures for maintain care plan included in the updated program Description. | Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description. V3 (located in 6.0) | Section 4.2, Number 4.2.3 -4.2.10<br><br>Section VI – Plan of Care<br><br>Health Action Plan and Person Centered Care Plan | Pages 4-5<br><br>Pages 12-13<br><br>Page 18 |
| 6.38.8 | Coordinate Case Management activities for members also receiving services through the MCO's Chronic Care Management Program. | Met:<br>Person Centered Care Model Program Description, pg 12, Population Based Disease Management (DM)/Chronic Care Management (CCM) | Community & State Condition Specific CM_DM Program Enrollment Job Aid<br><br>Community & State Intensive Medical Behavioral Case Management Program (located in 6.34)<br><br>Person Centered Care Model Program Description (located in 6.29) | Purpose<br>Overview<br>DM Program Enrollments<br><br>Section 4.1, Number 4.1.3<br><br>Integration of Medical and Behavioral Health Population based DM/CCM Program | Page 1<br>Page 1-2<br>Page 2<br><br>Page 4<br><br>Page 9<br><br>Pages 11-12 |
| **6.39** | **Chronic Care Management Program (CCMP)** | | | | |
| 6.39.1 | 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. | Met<br><br>Hep C is included in the updated documentation | Person Centered Care Model Program Description (located in 6.29)<br><br>Community & State Condition Specific CM_DM Program Enrollment Job Aid<br><br>PCCM Louisiana Addendum (located in 6.0) | Population Based DM/CCM Program<br><br>Purpose<br>Overview<br>DM Program Enrollments<br><br>Chronic Care Management Program Conditions | Pages 11-12<br><br>Pages 1<br>Page 1-2<br>Page 2<br><br>Page 1 |
| 6.39.3 | The MCO shall also include one of the following chronic conditions in the | **Met :** | Person Centered Care Model Program | Population Based | Pages 11-12 |

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| | 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. | CAD and COPD listed in Community & State Condition Specific CM_DM Program Enrollment Job Aid, pg 1 | Description (located in 6.29)<br><br>Community & State Condition Specific CM_DM Program Enrollment Job Aid | DM/CCM Program<br><br>Purpose<br>Overview<br>DM Program Enrollments | <br><br>Page 1<br>Page 1-2<br>Page 2 |
| 6.39.4 | 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: | Met<br><br>30-day submission timeframe included in the resubmitted documentation. | Community & State Condition Specific CM_DM Program Enrollment Job Aid<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>PCCM Louisiana Addendum (located in 6.0) | All sections<br><br>Population Based DM/CCM Program<br><br>Program Documentation | All pages<br><br>Pages 11-12<br><br>Page 2 |
| 6.39.4.1 | Include the definition of the target population; | Met:<br>Person Centered Care Model Program Description, pg 13, Identification | Person Centered Care Model Program Description (located in 6.29)<br><br>Community & State Condition Specific CM_DM Program Enrollment Job Aid | Member Identification and Risk Stratification<br><br>Overview<br>DM Program Enrollments | Pages 12-13<br><br>Pages 1-2<br>Pages 2-3 |
| 6.39.4.2 | Include member identification strategies, i.e. through encounter data; | Met:<br>Community & State Condition Specific CM_DM Program Enrollment Job Aid, pg 2, Identification of Members | Community & State Condition Specific CM_DM Program Enrollment Job Aid<br><br>Person Centered Care Model Program Description (located in 6.29) | Identification of Members<br><br>Member Identification and Risk Stratification | Page 2<br><br>Page 12-13 |
| 6.39.4.3 | Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee; | Met:<br>Person Centered Care Model Program Description , pg 5, Clinical Practice Guidelines | Person Centered Care Model Program Description (located in 6.29) | Clinical Practice Guidelines<br>Appendix A | Page 5<br>Pages 20-31 |
| 6.39.4.4 | Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions; | Met:<br>Person Centered Care Model Program Description, Appendix B | Person Centered Care Model Program Description (located in 6.29) | Appendix B | Pages 32-36 |
| 6.39.4.5 | Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions; | Met<br>Addressed in documents resubmitted by UHC post onsite visit | Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description. V3 (located in 6.0) | Appendix B<br><br>Population based DM/CCM program | Pages 32-36<br><br>Pages 12-13 |
| 6.39.4.6 | Include methods for informing and educating members and providers; | Met: | Informing and Educating Providers Policy | V Policy Provisions, | Page 1 |

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| | | Informing and Educating Providers Policy, pg 1, Policy Provisions | Person Centered Care Model Program Description (located in 6.29) | Section B<br><br>Transitional Case Management<br>Member Enrollment and Program Information<br>Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Page 9<br><br>Page 14-15<br><br>Pages 15-16 |
| 6.39.4.7 | Emphasize exacerbation and complication prevention utilizing evidence-based clinical practice guidelines and patient empowerment and activation strategies; | Met<br><br>Prevention and patient empowerment strategies are included in the resubmitted documentation. | Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description. V3 (located in 6.0) | Appendix A<br><br>Health Assessments | Pages 20-31<br><br>Page 17 |
| 6.39.4.8 | Conduct and report the evaluation of clinical, humanistic and economic outcomes; | Met<br><br>Resubmitted documentation includes reference to economic outcomes. | Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>Person Centered Care Model Program Description. V3 (located in 6.0) | Case Management Program Evaluation<br><br>Case Management Program Evaluation | Page 18<br><br>Page 20 |
| 6.39.4.9 | Address co-morbidities through a whole-person approach; | Met:<br>Person Centered Care Model Program Description, pg 15, Health Assessments | Person Centered Care Model Program Description (located in 6.29) | Introduction and Scope Objectives<br>Health Action Plan (HAP) and Person Centered Plan of Care (POC) | Pages 3-4<br>Page 4<br>Pages 15-16 |
| 6.39.4.10 | Identify members who require in-person case management services and a plan to meet this need; | Met:<br>Person Centered Care Model Program Description, pg 10, Community Engagement | Community & State Community Engagement Program Procedure<br><br>Person Centered Care Model Program Description (located in 6.29) | Section 3 – Initial Field Outreach<br><br>Sections 5.4, Section 6<br><br>Sections 11- 13<br><br>High Risk Medical/Behavioral Case Management | Page 3<br><br>Page 6<br><br>Pages 9 – 10<br><br>Pages 8-9<br><br>Pages 9-10 |

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| | | | | Transitional Case Management<br>Community Engagement<br>Member Enrollment and Program Information | Page 10<br>Pages 14-15 |
| 6.39.4.11 | Coordinate CCMP activities for members also identified in the Case Management Program; and | Met:<br>Person Centered Care Model Program Description, pg 12, Population Based DM/CCM | Community & State Condition Specific CM_DM Program Enrollment Job Aid<br><br>Person Centered Care Model Program Description (located in 6.29) | Purpose<br>Overview<br>DM Program Enrollments<br><br>Integration of Medical and Behavioral Health Population Based DM/CCM Program | Page 1<br>Page 1-2<br>Page 2<br><br>Page 9<br><br>Pages 11-12 |
| 6.39.4.12 | Include Program Evaluation requirements. | Met:<br>Person Centered Care Model Program Description , pg 18, CM Program Evaluation | Person Centered Care Model Program Description (located in 6.29) | Case Management Program Evaluation | Page 18 |
| **6.40** | **Predictive Modeling** | | | | |
| 6.40.1 | The MCO shall use predictive modeling methodology to identify and stratify members eligible for the CCMP. | Met:<br>PCCM Program Description discusses identification and stratification of members and the use of predictive modeling (pgs 12-14) | Identification of High Risk Members for CM<br><br>Person Centered Care Model Program Description (located in 6.29)<br><br>Impact Pro White Paper | Section V- Policy Provisions, B5<br><br>Member Identification and Risk Stratification<br><br>Overview | Page 2<br><br>Pages 12-13<br><br>Page 2 |
| 6.40.2 | The MCO shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include but are not limited to: | Met:<br>Impact Pro White Paper lays out specifications of Methodology (Key Steps in Measuring Patient Risk) , *but no mention of 30 day submission requirement* | Impact Pro White Paper | Key Steps in Measuring Patient Risk | Pages 3-4 |
| 6.40.2.1 | A brief history of the tool's development and historical and current uses; | Met:<br>Identification of High Risk Members for CM | Impact Pro White Paper<br><br>Identification of High Risk Members for CM | Impact Pro Validation<br><br>Section V- Policy | Pages 8-9<br><br>Page 2 |

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| | | discusses Impact Pro history and how used | | Provisions, B1 | |
| 6.40.2.2 | Medicaid data elements to be used for predictors and dependent measure(s); | Met:<br>Impact Pro White Paper-Key Steps in Measuring Patient Risk | Person Centered Care Model Program Description (located in 6.29)<br><br>Impact Pro White Paper | Member Identification and Risk Stratification<br><br>Key Steps in Measuring Patient Risk | Pages 12-13<br><br>Pages 3-4 |
| 6.40.2.3 | Assessments of data reliability and model validity; | Met:<br>Impact Pro White Paper section addressing validation | Impact Pro White Paper<br><br>Identification of High Risk Members for CM | Impact Pro Validation<br><br>Section V – Policy Provisions, B10 | Pages 8-10<br><br>Page 2 |
| 6.40.2.4 | A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and | Met:<br>Impact Pro White Paper, Key steps in measuring patient risk (Data Prep, Episode of Care grouping, Episode Based Markers, Service Based markers, Clinical Profiles, Weighting of profiles to compute risk, Complete member risk profile, Outputs | Impact Pro White Paper | Key Steps in Measuring Patient Risk | Pages 3-4 |
| 6.40.2.5 | A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population. | Met:<br>PCCM Program Description-Member identification and Risk Stratification Process for PCCM (pgs 12-13) describes optimization.<br><br>Resubmitted documentation includes constraints on intervention to the Medicaid program. | Person Centered Care Model Program Description (located in 6.29)<br><br>Identification of High Risk Members for CM Louisiana (located in 6.0) | Member Identification and Risk Stratification<br><br>Constraints | Pages 12-13<br><br>Page 3 |